Health and Social Care Scrutiny Sub-Committee AGENDA

DATE: **Monday 26 October 2015**

TIME: **7.30 pm**

VENUE: **Committee Rooms 1 & 2, Harrow Civic Centre**

MEMBERSHIP **(Quorum 3)**

Chair: **Councillor Mrs Rekha Shah**

Councillors:

Michael Borio
Margaret Davine (VC)
Mrs Vina Mithani
Chris Mote

Reserve Members:

1. Kairul Kareema Marikar
2. Jo Dooley
3. Sasi Suresh

1. Lynda Seymour
2. Jean Lammiman

Advisers:

Julian Maw — Harrow Healthwatch
Dr N Merali — Harrow Local Medical Committee

Contact: **Manize Talukdar, Democratic & Electoral Services Officer**
Tel: 020 8424 1323 E-mail: manize.talukdar@harrow.gov.uk

Harrow COUNCIL LONDON

AGENDA - PART I

1. ATTENDANCE BY RESERVE MEMBERS

To note the attendance at this meeting of any duly appointed Reserve Members.

Reserve Members may attend meetings:-

(i) to take the place of an ordinary Member for whom they are a reserve;
(ii) where the ordinary Member will be absent for the whole of the meeting; and
(iii) the meeting notes at the start of the meeting at the item 'Reserves' that the Reserve Member is or will be attending as a reserve;
(iv) if a Reserve Member whose intention to attend has been noted arrives after the commencement of the meeting, then that Reserve Member can only act as a Member from the start of the next item of business on the agenda after his/her arrival.

2. DECLARATIONS OF INTEREST

To receive declarations of disclosable pecuniary or non pecuniary interests, arising from business to be transacted at this meeting, from:

(a) all Members of the Sub-Committee;
(b) all other Members present.

3. MINUTES (Pages 5 - 10)

That the minutes of the meeting held on 8 June 2015 be taken as read and signed as a correct record.

4. PUBLIC QUESTIONS *

To receive any public questions received in accordance with Committee Procedure Rule 17 (Part 4B of the Constitution).

Questions will be asked in the order notice of them was received and there be a time limit of 15 minutes.

[The deadline for receipt of public questions is 3.00 pm, 21 October 2015. Questions should be sent to publicquestions@harrow.gov.uk

No person may submit more than one question].

5. PETITIONS

To receive petitions (if any) submitted by members of the public/Councillors under the provisions of Committee Procedure Rule 15 (Part 4B of the Constitution).

6. REFERENCES FROM COUNCIL AND OTHER COMMITTEES/PANELS

To receive any references from Council and/or other Committees or Panels.

7. LONDON NORTH WEST HEALTHCARE NHS TRUST UPDATE REPORT (Pages 11 - 32)

Report of Director of Strategy, London North West Healthcare NHS Trust.

8. DENHAM INTERMEDIATE CARE UNIT -TRANSFER OF SERVICE TO CENTRAL MIDDLESEX HOSPITAL SITE (Pages 33 - 40)

Report of the Community Services Director for Brent and Harrow, London North West Healthcare NHS Trust.

9. HARROW LOCAL SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2014/15 (Pages 41 - 132)

Report of the Director of Adult Social Services.

10. ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH (Pages 133 - 178)

Report of the Director of Public Health.

11. HEALTH AND WELLBEING STRATEGY (Pages 179 - 216)

Report of the Director of Public Health.

12. JOINT HEALTH OVERVIEW SCRUTINY COMMITTEE UPDATE (Pages 217 - 222)

Report of Divisional Director Strategic Commissioning.

AGENDA - PART II - NIL

*** DATA PROTECTION ACT NOTICE**

The Council will audio record item 4 (Public Questions) and will place the audio recording on the Council's website, which will be accessible to all.

[**Note:** The questions and answers will not be reproduced in the minutes.]

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HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE

MINUTES

8 JUNE 2015

Chair:	*	Councillor Mrs Rekha Shah		
Councillors:	*	Margaret Davine	*	Mrs Vina Mithani
	*	Kairul Kareema Marikar (1)	*	Chris Mote
Advisers:		Julian Maw	-	Harrow Healthwatch
	*	Dr N Merali	-	Harrow Local Medical Committee

* Denotes Member present
(1) Denotes category of Reserve Members

39. Attendance by Reserve Members

RESOLVED: To note the attendance at this meeting of the following duly appointed Reserve Members:-

Ordinary Member	Reserve Member
Councillor Michael Borio	Councillor Kairul Kareema Marikar

40. Declarations of Interest

RESOLVED: To note that the following interests were declared:

All Agenda Items
Councillor Kairul Kareema Marikar declared a non-pecuniary interest in that she carried out voluntary work for the Harrow Association of Disabled People

and worked in the mental health field. She would remain in the room whilst the matters were considered and voted upon.

Councillor Chris Mote declared a interest in that his daughter was employed at Northwick Park Hospital. He would remain in the room whilst the matters were considered and voted upon.

41. Appointment of Vice-Chair

RESOLVED: That Councillor Margaret Davine be appointed Vice-Chair for the 2015/16 Municipal Year.

42. Minutes

RESOLVED: That the minutes of the meeting held on 5 February 2015 be taken as read and signed as a correct record.

43. Public Questions and Petitions

RESOLVED: To note that no public questions or petitions were received at this meeting.

44. References from Council and Other Committees/Panels

RESOLVED: To note that none were received.

RECOMMENDED ITEMS

45. Appointment of Advisers 2015/16

RESOLVED: That the following nominees be appointed as Advisers to the Sub-Committee for the 2015/16 Municipal Year:

1. Mr Julian Maw (HealthWatch Harrow)
2. Dr Nizar Merali (Harrow Local Medical Committee)

RESOLVED ITEMS

46. Joint Health Overview & Scrutiny Committee Update

The Sub-Committee received an update report on the outcomes of the Joint Health Overview & Scrutiny Committee meeting held on 3 March 2015.

Following questions from Members, an officer advised that as part of its inspection of the London Ambulance Service (LAS), the Care Quality Commission (CQC) had requested Harrow to provide feedback to the CQC regarding the LAS's performance locally, and that Members' comments had been fed back to the CQC.

47. Healthwatch Update Report

The Sub-Committee received a report of the Divisional Director of Strategic Commissioning which provided an update on the work of the Harrow Healthwatch.

Following questions and comments from Members of the Sub-Committee, an officer advised that

- the new contract for Healthwatch Harrow had been awarded to Harrow in Business for a further three years, with the option to extend the contract for an additional two years;

- the Council decided to reduce the budget for Healthwatch by 43% for the current and future financial years. The reduction equated to approximately £80k. The decision to reduce the budget was related to the volume of activity that the service needed to undertake rather than being based around the indicative un-ring-fenced grant that the Government had provided;

- a report regarding Healthwatch Harrow's priorities and work programme for 2015/16 would be submitted to the next meeting of the Sub-Committee.

RESOLVED: That the report be noted.

48. Harrow's Local Account 2013/14

The Sub-Committee received a report of the Corporate Director of Community, Health & Wellbeing which set out the main elements of the Harrow Local Account Report 2013/14.

Following a brief overview of the report, an officer responded to questions and comments as follows:

- the Local Account document had been a collaborative project and been co-produced with service users and carers and was aimed at the whole community;

- a 6-month review of the implementation of the Care Act would be carried out in October 2015 and this would be reported at a future meeting of the Sub-Committee;

- there had been a 15% increase in demand for Adult Social Care, however, the anticipated demand from carers had been lower but is likely to increase over the year;

- service users, carers and third sector groups were beginning to understand the implications of the Care Act leading to increased demand as awareness grows;

- under the Care Act, existing care structures would be retained. As carers would now have the same rights as service users carers would

be offered up to six weeks free Reablement service and were being given advice on how to access universal services available in the Community;

- as part of the Council's savings targets there would need to be further savings. Officers would provide Members with the necessary information to make informed decisions about further savings, while alerting them to the risks;

- there had been a sharp increase in the number Adult Social Care referrals and in the number of cases of DOLs (Deprivation of Liberty). DOLs cases had increased by 3000%, however, the timeframes for these had not been breached and there was no waiting list;

- there was a dedicated Safeguarding contact and investigation team whose responsibility it was to assess whether a safeguarding enquiry was necessary and to carry out investigations.

Members of the Sub-Committee congratulated officers for the excellent report.

RESOLVED: That the report be noted.

49. Developing a protocol for the working relationship between Scrutiny, the Health & Wellbeing Board and Healthwatch Harrow

The Sub-Committee received a report of the Divisional Director of Strategic Commissioning which set out the rationale behind developing a draft protocol for the working relationship between Harrow's scrutiny function, the Health & Wellbeing Board and the local Healthwatch.

Following a brief overview of the report, an officer responded to questions as follows:

- the Protocol had been drawn up on the basis of guidance from the Centre for Public Scrutiny, the Local Government Association and the Department of Health;

- overall responsibility for the scrutiny function lay with the Overview & Scrutiny Committee, which would delegate discrete areas of work to the Health & Social Care Scrutiny Sub-Committee.

RESOLVED: That

(1) the suggested set of shared principles, as outlined in the report be agreed;

(2) the report be noted.

50. Any Other Business

RESOLVED: To note that, following a suggestion by the Chair, Members of the Sub-Committee agreed to visit the Accident and Emergency unit at Northwick Park Hospital before the next meeting of the Sub-Committee.

(Note: The meeting, having commenced at 7.30 pm, closed at 8.30 pm).

(Signed) COUNCILLOR MRS REKHA SHAH
Chair

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REPORT FOR:	**HEALTH & SOCIAL CARE SCRUTINY SUB-COMMITTEE**
Date of Meeting:	26 October 2015
Subject:	London North West Healthcare NHS Trust Update Report
Responsible Officer:	Simon Crawford Director of Strategy, LNWHT
Scrutiny Lead Member area:	Councillor Michael Borio, Policy Lead Member & Councillor Mrs Vina Mithani, Performance Lead Member
Exempt:	No
Wards affected:	All
Enclosures:	Appendix 1: First year as LNWHT - Priorities and Challenges

Section 1 – Summary and Recommendations

This report provides an update from London North West Healthcare Trust's (LNWHT) on the priorities and challenges faced during the first year as a new Trust; provides an update on the progress since the Care Quality Commission's (CQC) inspection in May 2014 which is incorporated into the planning for the CQC inspection taking place week commencing 19th October 2015; and lastly provides an update on preparing for winter pressures at Northwick Park Hospital Emergency Department.

Recommendations:
The Health and Social Care Sub Committee are asked to note the updates.

Section 2 – Report

1. First year as London North West Healthcare Trust - Priorities and Challenges

On the 1st October 2015 London North West Healthcare NHS Trust celebrated its first full year following the merger of Ealing Hospital and North West London Hospitals.

The new organisation was created on the strength of the considerable clinical opportunities that bringing together clinicians and services into a single entity would bring, especially to the 850,000 people of the three boroughs for whom the Trust is the main local provider of healthcare.

The vision of the Trust and focus of its ongoing development is to transform itself into an integrated care organisation combining services that span community, acute, specialist and tertiary healthcare; with a commitment to work with partners in health, social care and the community.

Ambitions so improve health outcomes and provide care closer to home that were central to Shaping a Healthier Future set continues to be important in shaping the direction of travel across northwest London. For the Trust this has meant the closure of A&E at Central Middlesex Hospital (CMH) and the closure of maternity services at Ealing Hospital (EH), both of which have been achieved safely. Facilities at Northwick Park Hospital (NPH) have been substantially improved through the building of a new A&E department and upgrading of theatres. November will see the opening of a new emergency admission facility and state of the art infectious disease unit.

An immediate and positive consequence of the merger has been the ability of the expanded medical teams to support seven day working and improve senior decision-making presence, in particular to support emergency cover

out of hours. This had been an increasing challenge for the legacy organisations.

As is the case across the NHS, the Trust is facing considerable pressures. Though we believe the organisation is better placed to address these as a larger organisation. Some issues are national such as the ongoing difficulties recruiting skilled staff, increasing demand for healthcare as people live longer and the annual challenge of winter.

The Trust has not been able to consistently achieve national performance standards for A&E, in particular at NPH, referral to treatment and cancer waiting times. Considerable clinical and operational resources continue to be focusing on these issues, supported by substantially improved information flows and more robust planning of capacity and demand. However, all three targets continue to present considerable challenges.

Locally, ongoing discussions are taking place with commissioners over the future of CMH and EH. In addition, the ambitious procurement agenda being pursued by local commissioners has resulted in the Trust losing activity and income and this is having an impact on the sustainability of the Trust's community services in general, and on the specialist services that are affected such as cardiology.

The Trust's financial deficit continues to be a significant cause of concern and focus of activity. Implementing the recommendations of the Royal College of Nursing on staffing ratios led to significant increases in spending across the Trust in 2014/15. Attendances in A&E and the associated admissions for emergency care also resulted in significantly higher costs for the Trust as additional beds were opened and extended opening hours were put in place for support services like diagnostics, pharmacy and senior consultants working hours.

However, the new leadership team that is now in place are focusing on the major opportunities that exist across the Trust. A critical review of the Trust's clinical strategy is underway in the context of the national agenda set by the Five Year Forward View. We recognise that hospital Trusts will play a fundamentally different role in the future as participants in integrated care models that are anchored in the community, involving a wide-range of partners. Key elements of the clinical strategy are expected to be:

- A centre of excellence and hub for the emergency pathway at NPH
- A local hospital and centre of excellence for elderly care and rehabilitation at EH
- A centre of excellence for elective surgery, and potential host site for regional rehabilitation and a national genomic testing facility at CMH
- A centre of excellence for local cancer services in northwest London
- An international centre of excellence for care, research and specialist training in the treatment of colorectal disease; and
- A major provider of healthcare education and training.

In addition to supporting a group of newly-appointed clinical leaders who are bringing together colleagues from services across all sites, we have put in

place streamlined governance arrangements to ensure a more visible leadership presence and to more effectively hold ourselves to account for the care we deliver to patients.

The CQC inspection that is currently underway is being used as a further opportunity to critically assess where we need to improve as well as to identify the many areas of excellent practice and high quality care our clinical staff provide. The leadership will use the review to improve the focus on safety, quality and the patient experience: from ward to Board.

Alongside the improvement challenge we have set our clinical teams, a series of measures are in place to streamline the operational efficiency of the Trust. Key to this financial recovery programme is the ambition to become agency free coupled with an exciting transformation agenda. Using the full scope of our community and acute services, and working with partners, to develop fundamentally new ways of working that provide the best possible care to our patients and allow the Trust to thrive.

The completion of a new ward block adjacent to A&E at NPH, which opens in November, will provide additional bed capacity that will benefit A&E performance directly and ease pressure on site occupancy as a whole.

Strengthening relationships with our partners is a priority and we recognise that our long-term strategy needs to reflect the needs of a wide range of stakeholders. However, we also believe that our partners – including local authorities – have an important role to play in helping the Trust find solutions to the challenges of Shaping a Healthier Future, in particular over the future of the CMH and EH.

Appendix 1 summaries the challenges and priorities faced by LNWHT.

2. Progress on CQC action plan following inspection May 2014

2.1 Position

The North West London Hospitals NHS Trust was inspected in May 2014 under the new style CQC methodology. The overall provider report was rated as follows:

- **Safe:** Requires Improvement
- **Effective**: Requires Improvement
- **Caring**: Requires Improvement
- **Responsive**: Requires Improvement
- **Well Led**: Requires Improvement

The CQC will be inspecting the newly formed London North West Healthcare NHS Trust in October 2015; Ealing Hospital and Community services will be inspected for the first time under the new methodology.

2.2 Governance

Post inspection the Trust prepared an action plan which was shared with key stakeholders, however since that time as a result of the merger and leadership

changes at the Trust there has been poor internal governance and oversight of the delivery and implementation of the original action plan. Recent monthly governance submissions to the NHS Trust Development Agency (TDA) have been altered to reflect this finding.

New governance arrangements in the Trust (from August 2015) have been implemented to ensure greater oversight and assurance that the appropriate actions have been fully implemented or are actively being monitored for completion.

2.3 Preparation for 2015 Inspection

A TDA Mock Clinical Review took place in the Acute Hospitals on Friday 11 September 2015 and Community Mock Clinical Review took place on 1 October 2015. This was conducted in preparation for the 2015 inspection. In addition a key focus of the clinical reviews was to assess the degree to which the 2014 original improvement plan had been achieved and embedded in Practice.

The clinical review identified areas of good practice; this included the significant work that had been undertaken to encourage the reporting of incidents within the organisation, a point to be improved upon was that of sharing the learning from those incidents. Work continues to improve the governance structure and the "you said we did" notice boards for patients and relatives have been rolled out across all sites.

In the community the TDA clinical review praised the provision of end of life care, describing it as excellent within community settings. An area for action for the community services was to ensure that policies and guidelines are current and accessible.

2.4 Executive Actions

A paper was presented to the June Board 2015 listing the outstanding actions that needed to be taken and requiring executive oversight and management. The Trust was given a list of "**Must Do's" "Should** Do's" and **Compliance Actions**. Must do's are linked to compliance actions and action must be taken, should do's are recommendations and compliance actions are applied when the inspection team note and have **evidence of noncompliance with the Regulatory Standards** therefore a breach in compliance is identified and the providers are required to take action to address and return to being fully compliant as soon as possible.

Below is an update on the Trust position in respect of all the compliance actions that must have been addressed in advance of the 2015 inspection.

Core Services	Compliance Actions	Action to date
A&E	There were inadequate staffing levels to provide safe care to patients within major's treatment area in the A&E department	Staffing levels very good in A&E, now compliant
Critical Care	Very little information was systematically collected on the safety and quality of care and treatment provided within critical care	Unit now submits to ICNARC and data is displayed on the unit
	Medical staffing levels were very low in	New Consultant lead and

	critical care. A large number of positions were filled by locums and clinical fellows. The trainees in the department were very junior and unable to take on many tasks independently	staffing has improved.
Surgery	There were a lack of up to date protocols and guidelines for staff to work from within surgery	Work underway to ensure all trust policies are in date and include up to date evidence based practise
	There were low numbers of middle grade doctors in general surgery	There are on-going challenges recruiting Dr's to St Marks and actions are in place to address this. We have also introduced a new role, a Senior Nurse Role commonly known as Red coats to address the known gap in middle grade Dr's.
Maternity	The maternity service did not respond to complaints in a timely manner, nor did it actively seek women's feedback on the maternity pathway.	Management of complaints much improved, with CEO focus to improve the quality and timeliness of responses. Further work has taken place to gather direct feedback from patients and more action has been agreed to address the latest findings. A new post created of Quality & Patient Experience Manager.
	Lack of escalation processes in Maternity.	Policy was reviewed July 2015, and amended version due to be ratified imminently and uploaded on intranet. Daily safety huddles introduced from May 2015 aimed at matching safe staffing level with patient demands.
	Women who use maternity services were not protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of: Having their individual needs met as comfort checks on the postnatal ward were not regular.	Comfort checks take place 6 hourly on post natal ward, collated and reported on monthly, there are 31 beds with 5 midwives and 3 MCA's, in the day and in the evening 4 midwives and 2 MCA's the area is adequately staffed.
	Having their safety and welfare ensured because behaviour and attitudes of some midwives towards women fell below expectations	Maternity services established a strategy for compassion, quality and safety in practise, regular meetings held and a card given. Enhanced customer care training is now within mandatory training. Further work planned in light of recent survey feedback. The department is also delivering on the outcomes of two independent maternity reviews that were commissioned

		by the division.
Children	The design of the ward meant that many areas were not observable from the nurses' station, or the reception desk, which posed a safety risk when children were playing in the ward	Ward refurbishment complete and now providing an excellent patient environment.
	The ward appeared clean, but it was cluttered which meant thorough cleaning could not be achieved.	Mock inspections have taken place, with appropriate follow up actions taken and deep clean. Further mock review planned on completion of refurbishment
	The treatment room and store room doors on the ward were left open, potentially allowing access to children.	All staff now aware of importance and appropriate locks etc. in place
	Blood samples were on a shelf in the open area of Jack's Place awaiting collection, because the pneumatic tube system to take samples to the lab was out of order	Staff aware and senior staff clear on holding to account for practises of all professionals
	Not all equipment in the ward was on the trust's asset register, which was why service dates had been overlooked.	All equipment in this area compliant. Work underway to ensure equipment is compliant across trust.
	Some electrical equipment did not have PAT testing dates, and trust records showed that on the children's ward 24% of equipment had passed their due date for servicing	As above all compliant in this area.
Neonatal Unit	Fridge in the Neonatal unit was iced up and there were gaps in temperature recording	Mock inspections have taken place, pharmacy have updated policies and practices and are undertaking frequent audits to ensure sustained compliance.

3. Preparing for Winter Pressures at Northwick Park Hospital Emergency Department

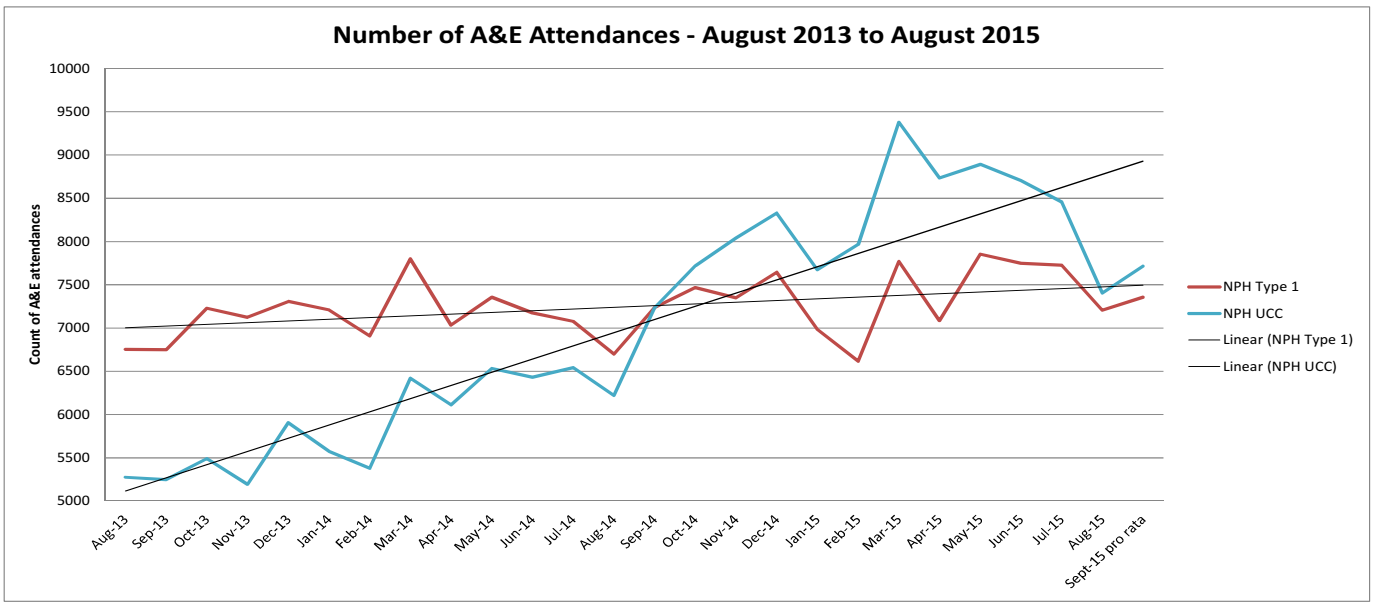
3.1 Background

The Emergency Department (ED) at Northwick Park Hospital is an exceptionally busy environment. Attendances have grown steadily as indicated in the below graph.

Monthly urgent care centre (UCC) type 3 attendances have increased from an average of 5200 per month (Aug 2013), peaking at 9400 in March 2015 and an average between 7000-8000 per month over the last 4 months.

Monthly A&E type 3 attendances have increased from an average of 6700 per month (Aug 2013) to an average of 7500 per month over the last 4 months i.e. 250 per day.

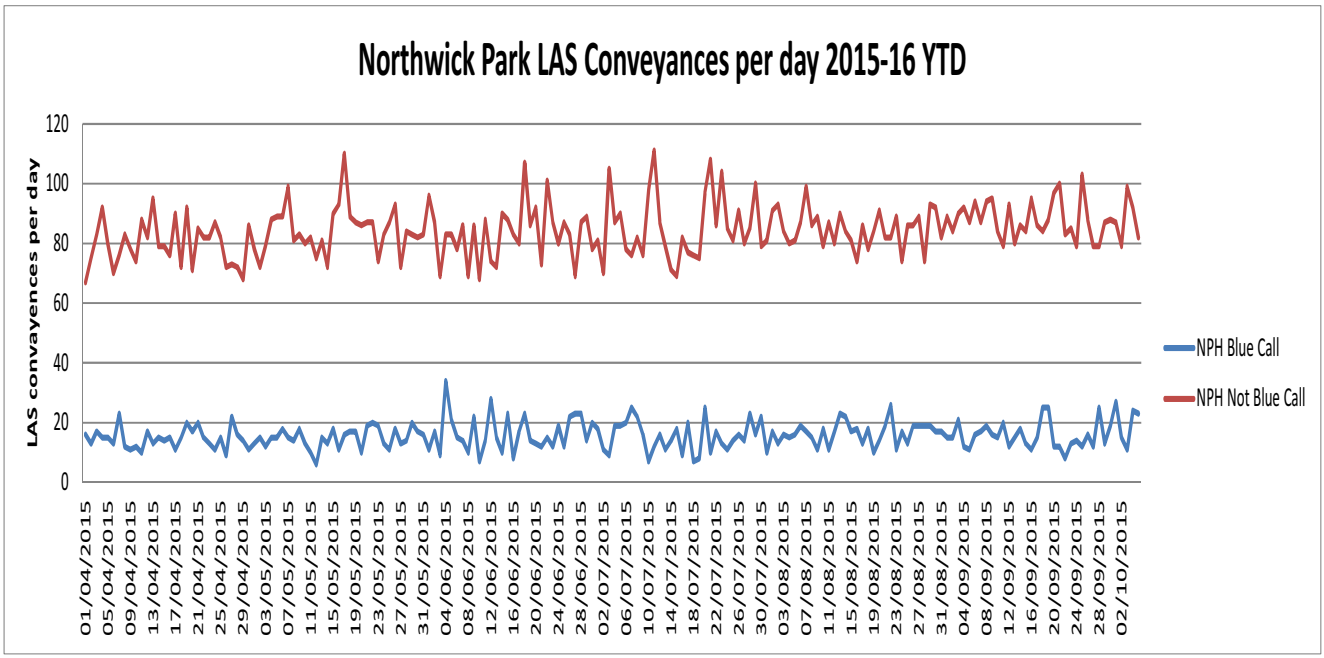
The department has recently been relocated within the hospital and benefits from a new purpose built department with streamlined access to a number of supporting services and inpatient wards.



There are a number of factors for this increase in activity, including:

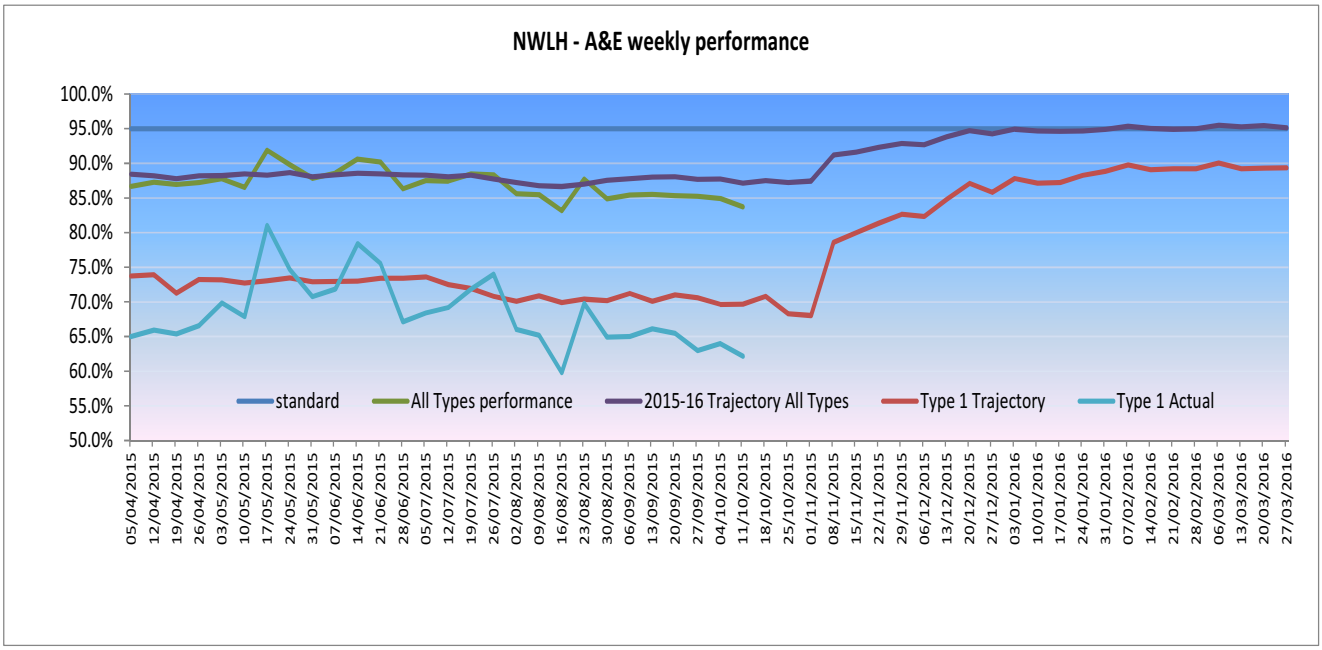
- The local demographics and age profile of Harrow residents i.e. aging population, increased co-morbidities, working population reliance on 24/7 services as a place of safety when other health and social care services are not available
- Increased complexity of presentation to ED
- Limited access to primary care across seven days
- Limited access to social care across seven days
- Public education on local services and awareness of how and when to access
- Harrow CCG commissioning a 24/7 UCC on site where previously a reduced hours service was operational
- The impact of the London Shaping a Healthier Future Programme i.e. relocation of ED departments across London and wider hospital services

- There is a large variation in the number of London Ambulance Service conveyances. YTD 15/16 the average number of conveyances is 100. However the below graph indicate the variation in daily activity the ED experiences which has an effect on daily performance to support the safe delivery of the national 95% of patients seen in ED within 4 hours.



3.2 4 hour 95% trajectory:

To support the delivery of the 95% target, the Trust has agreed with CCGs commissioners a trajectory. This is being monitored daily and discussed at the Brent and Harrow System Resilience Board where joint plans and mitigations are developed to support system performance.



A range of factors are impacting this delivery, including:

- Delays in the impact of the CCG and Social Care Better Care Fund Plans

- Medically fit for discharge and delayed transfers of care are increasing across health and social care within Brent and Harrow

- Availability and access to community beds including respite beds, nursing home and residential home placements across health and social care

- Response from health and social care partner organisations to deliver elements of their pathways to the scale and pace required across 7 days

- Pathway delays between ED and specialty services

3.3 Preparing for Winter Pressures at Northwick Park Hospital Emergency Department:

The following actions will support the Trust this winter:

- Daily whole system teleconference focusing on medically fit for discharge and delayed transfers of care across Brent and Harrow including a single information sheet issued daily to ally required stakeholders

- Launch of the 2 week Breaking The Cycle programme to improve system working internally and externally to remove blockages in the system between 9-22 November 2015

- Increased bedded capacity at Northwick Park through:
    - Modular beds open 23 November 2015 adding an additional 48 new beds into the site. These beds will comprise of additional short stay assessment and medical beds
    - Reallocation of medical and surgical bed base to improve the efficiency of patient treatment through increased separation of medical and surgical beds which aims to reduce medical outliers on surgical wards
    - Increased mortuary capacity through a refurbishment completed by December 2015.

- Continued implementation of the ED Remedial Action Plan agreed with CCG commissioners which is monitored in the monthly System Resilience Board and actions worked upon at the fortnightly operational sub group

- Trust pathway changes including:
    - Continuation of the Care Pathway to support flow through the Northwick Park ED
    - Revised decision to admit pathways process between ED and specialties
    - Nurse led discharge bundles
    - Continuation of the Ambulatory Emergency Care Pathway to support increased flow of appropriate ambulatory day case activity to be treated away from the ED

- Improving site discharge flow through the expansion of the discharge lounge within September 2015.

- Discussions with CCGs as required on flexing admission criteria to community rehabilitation beds

- Joint working with Brent and Harrow CCGs to transfer appropriate medical fit patients to short stay step down beds

3.4 Implications to partner organisations – CCG and Social Care:

Partner organisations are aware of the need to support the delivery the 4 hour ED target across CCGs and Social Care responsible pathways. There are a number of implications that partners will need to be mindful of during the upcoming winter period, including:

- Requirement to act on pathway patients in a timely process to avoid delayed transfers of care
- Consideration to the impact of time delays for social care panel sign off

Section 3 - Statutory Officer Clearance

Not Required

Ward Councillors notified:	**NO**

Section 4 - Contact Details and Background Papers

Contact: Simon Crawford, Director of Strategy, simon.crawford1@nhs.net , 0208 869 2005

Background Papers: None

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Stronger Together

London North West Healthcare NHS Trust

First year as a new Trust: challenges and priorities

Harrow HOSC
26th October 2015

London Northwest Healthcare

An integrated organisation delivering acute and community care for the boroughs of Brent, Harrow and Ealing; and specialist and tertiary services for London and nationally

The Trust in numbers…

- Serves a local population of over 850,000
- 8,500 staff
- 1,240 inpatient beds
- Annual spend of £737m and income of £681m
- Each day:
  - 780 A&E and urgent care centre attendances
  - 150 ambulances
  - 2,000 outpatient appointments
  - 430 admissions

Recent accolades

- Medicine management programme received 2015 HSJ Award
- Wolfson Unit for Endoscopy designated as the UK's only World Centre of Excellence

Highlights and achievements

- Successfully merged on 1 October 14
- Major service changes delivered safely
  - New A&E at NPH
  - CMH A&E and EH maternity closures
- Additional bed capacity approved – fast-track construction nearing completion
- Emergency pathways streamlined and ambulatory care expanded
- Early implementation of seven-day working
- First steps towards creating an elective surgery centre of excellence – orthopaedics as pioneering service
- 2015 junior doctors' survey 2015 one of the best in London

Ongoing challenges

- Putting in place leadership
- Uncertainty affecting recruitment and the operating plan
  - SaHF programme unable to agree future of EH and CMH
  - Aggressive decommissioning decisions by CCGs
- Performance against national standards for A&E at NPH, referral-to-treatment times and cancer waits
- Winter pressures
- Financial deficit - merger costs, structural deficit, safer staffing,* lost income
- Feedback from staff and patients

*£39million additional spend in 2014/15

Organisational vision and objectives

We want to be an organisation of choice for staff and patients, providing excellent clinical care and a good patient experience

- Improve our focus on safety and quality
- Improve patient experience, satisfaction and engagement
- Track and manage performance to identify and resolve issues early
- Develop and retain our workforce and empower staff to improve services
- Ensure financial sustainability – doing the right thing first time
- Plan for our future – engage widely in setting our strategic direction

LNWHT has an unique opportunity to use its scale to achieve substantial performance, turnaround and transformation agendas

Specific priority actions

- ✓ New executive team in place by end of 2015
- ✓ Restructured board assurance arrangements to improve board-to-ward visibility and responsiveness
- ✓ Getting the cross-organisational divisional leadership and clinical leadership teams to work effectively
- ✓ Focus on performance and holding to account
- ❖ Policy harmonisation

Preparing for CQC inspection

- ❖ Action plans for all areas requiring improvement
- ❖ Recognising pockets of excellence

Responding to financial and workforce challenges

Finance

- ✓ Financial recovery programme
- ✓ Staffing and patient dependency reviews
- ✓ Becoming an “agency free” organisation
- ✓ Ambitious transformation programme

Workforce

- ❖ Improve recruitment and retention
- ❖ Middle and senior managers’ and clinical leaders’ development
- ❖ Explore new ways of working with community partners
- ❖ Review of culture and values

Emerging clinical strategy

- Clinical services seamlessly integrated with healthcare and non-healthcare services to reduce hospital admissions, increase access from home / in the community and support refocus on prevention
- Northwick Park as the centre of excellence and hub for the emergency pathway, including maternity services, with supporting 24/7 specialist services and critical care
- Ealing Hospital as the centre of excellence for elderly care and rehabilitation, and a local hospital for the people of Ealing
- Central Middlesex Hospital as the centre of excellence for elective surgery, host for regional rehabilitation services and national genomic testing facility
- A centre of excellence for local cancer services in northwest London
- An international centre of excellence for care, research and specialist training in the treatment of colorectal disease
- A major provider of healthcare education and training

Realising our ambition

- Enhance relationships with commissioners and other providers
- Improve our relationships with our local communities
- Live within our means – deliver financial balance
- Support of our partners is essential to achieve a sustainable solution for the Central Middlesex Hospital and Ealing Hospital sites

Recognition that this is not a quick fix but requires understanding that …

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"Change does not roll in on the wheels of inevitability, but comes through continuous struggle" *Martin Luther King Jr*

Harrow COUNCIL
LONDON

REPORT FOR: **HEALTH & SOCIAL CARE SCRUTINY SUB-COMMITTEE**

Date of Meeting:	26 October 2015
Subject:	Denham Intermediate Care Unit – Transfer of Service to Central Middlesex Hospital Site
Responsible Officer:	Mary Jamal, Community Services Director for Brent and Harrow, LNWHT
Scrutiny Lead Member area:	Councillor Michael Borio, Policy Lead Member & Councillor Mrs Vina Mithani, Performance Lead Member
Exempt:	No
Wards affected:	All
Enclosures:	None

Section 1 – Summary and Recommendations

This report sets out London North West Healthcare Trust's (LNWHT) plans for the re-location of the Denham Intermediate Care Unit on a medium-term basis (approximately 18 months) to Central Middlesex Hospital (CMH), Roundwood Unit, whilst an alternative suitable long-term location for the service is sought within the borough of Harrow. It also sets out the relocation intentions and actions that are being implemented to ensure that the needs of the Denham Unit patients and key stakeholders are met during this relocation period.

Recommendations:
The Health and Social Care Sub Committee is asked to consider and endorse LNWHT's plans to re-locate the Denham Unit.

Section 2 – Report

Introduction

The need to review the location of the Denham Unit at Rowanweald Care Home has arisen from a strategic options appraisal on the provision of intermediate care provided by the Denham Unit in July 2015. This options appraisal identified a number of clinical care, patient experience, infrastructure, efficiency and financial issues from continuing to provide the service from the existing site.

As a result LNWHT advised Harrow Clinical Commissioning Group (CCG) that the current facility is no longer able to meet the needs of current service provision and NHS quality standards in relation to the environment. Harrow CCG has confirmed its support for LNWHT to serve notice on the lease on the Denham Unit following the Trust's advice.

LNWHT's occupation of the Denham Unit at Rowanweald Care Home will cease in January 2016 with a view to the temporary relocation of the service to Central Middlesex Hospital (CMH). Further work will be undertaken to identify an alternative long term location for this service, ideally in the borough of Harrow. LNWHT proposes to undertake the relocation of the Denham Unit to CMH by January 2016 when the existing contract ceases.

LNWHT seeks to give assurance to stakeholders that the proposed move will not compromise patient quality & safety, available bed capacity and financial stability. On this basis a project team has been established to ensure the safe relocation of patients with input and engagement from stakeholder groups including the London Borough of Harrow.

Background

The Denham Unit is a 29 bedded Intermediate Care Unit, with an additional single continuing care bed, managed under LNWHT's Community Services. The Denham Unit is situated on the first floor of Rowanweald Nursing Home, which is owned by a private care home provider. LNWHT leases this space from the care home provider with a contract that incorporates managed facilities services for patients, such as patient meals, cleaning and building maintenance.

The Denham Unit was initially established in October 1998 to accommodate 30 continuing care patients for long term care following the closure of Harrow Hospital and Anmer Lodge Unit in Stanmore in 1998. A Service Level Agreement (SLA) for the unit was subsequently agreed between former NHS Harrow and the care home provider. An operational policy was devised which included the provision of care to a continuing care patient group.

In 2007 the Denham Unit's function evolved to include delivering a service for short-stay intermediate care patients with a higher level of care acuity. The unit now accommodates 29 intermediate care patients and 1 continuing care patient. The original service level agreement was not revised and updated to accommodate the changing requirements of the evolving service where there was an increased

throughput of patients. There was a consequential impact in that additional resourcing of the unit, particularly for estates and facilities needs, was not increased to meet this change in service provision. As a result nursing staff took on more housekeeping duties, for example, to ensure rooms were clean for new patients being admitted on the same day.

The Denham Unit has a key role in supporting Harrow patients to remain in their own homes, which is also a key priority for the Local Authority. As such opportunities for enhanced joint working with Social Care should also be considered by the Health and Social Care Scrutiny Sub-Committee as part of the recommended relocation.

Current situation

A review of current service requirements was undertaken and found that the existing Denham Unit facility based in Rowanweald Nursing Home has limitations in respect of meeting the minimum NHS standards to deliver high quality care.

The proposal for relocation of the Denham Unit was introduced on the basis of improving clinical care, patient experience feedback, infrastructure issues and financial efficiencies identified from an options appraisal as detailed in the 'why a change is needed' section below.

An initial project plan with milestones and key risks has been developed and a project group has been set up lead on the relocation of the Denham Unit to ensure the safe transfer of patients and service provision to CMH.

LNWHT recognises that engagement of our key stakeholders is essential in this process to ensure the safe and effective transfer of service provision, particularly for the local community and patients currently at the Denham Unit.

With this in mind the project group has a key responsibility to communicate to patients and local authority representatives on the aims of the proposed change. LNWHT also aims to give assurance through our mobilisation plan that the needs of this vulnerable group of patients will be effectively met during the transfer and in future service provision.

Specific separate consideration is also being given, with leadership from Harrow CCG, in relation to the remaining continuing care patient currently residing at the Denham Unit.

Why a change is needed

The case for change outlined in the LNWHT options appraisal consisted of three elements; Clinical care, infrastructure issues and financial/efficiency considerations.

Clinical care / Patient Experience

There are a range of issues in respect of the delivery of clinical care within the unit. These have been identified as follows:

- There is an overall lack of onsite storage facilities
- Patient facing time is being eroded as nursing staff are inappropriately being deployed to undertake housekeeping duties due to the lack of compliance against the housekeeping provisions made within the facilities provider contract.
- There is an overall lack of showering facilities within the 30 bedded unit, which compromises privacy and dignity for patients.
- The standard of routine cleaning is not consistent with NHS standards

- Items requiring repair, such as lights, are often deferred in the absence of an on-site handyman

Infrastructure

Infrastructure issues identified are as follows:
- Maintenance and upkeep of the facility and urgent support to business continuity in the event of unexpected crises, for example power failures, is not robustly provided at the current location
- There is a significant lack of showering facilities – one operational shower facility exists for 30 patients which is inadequate
- Access to and from the first floor is difficult when the single lift available is not working
- The general up-keep and infrastructure of the facility is not in line with NHS standards, for example, there is lack of mechanical ventilation in the sluice room
- Non-compliance of the environment with NHS infection control requirements, for example, the lack of clinical hand washing facilities for staff and in the communal areas and visitors

Efficiency/Finance

- The cost of occupying the existing unit represents 28% of the overall budget for the unit, which is higher than the usual ratio of costs for an inpatient unit run from an NHS site
- There is identified vacant inpatient space at CMH that could be utilised at marginal cost

Implications of the Recommendation

Considerations relating to the relocation of the Denham Unit to Central Middlesex Hospital include:

Resources: Costs

LNWHT anticipate a more efficient use of resources with the Denham Unit relocating to the CMH site through:
- The utilisation of currently vacant inpatient bedded space at CMH for the relocated Denham Unit Service
- Accessing existing facilities and estates services currently commissioned onsite at CMH

Staffing / Workforce

A staff engagement and then formal consultation process will be undertaken in line with LNWHT contractual employment obligations.

It is anticipated that for the period of the relocation of the service to CMH there will be a positive impact on staff recruitment with the service being relocated to an existing rust acute hospital site providing a high quality service delivery and learning environment.

Longer term, recruitment and retention of staff will be a key consideration in the identification of a permanent relocation of the Denham Unit within the borough of Harrow.

Equalities Impact

The specification for the Denham Unit will remain unchanged and as such the Denham Unit will remain accessible to patients with intermediate care needs that have a Harrow GP.

Community Safety

In line with Trust and Local Authority priorities the Denham Unit plays a role in supporting adults to be safe and independent in the community through positive risk assessment and management, physical rehabilitation, use of adaptive aids and the recommendation and facilitation of supported care in the community in collaboration with formal or informal carers.

Financial Implications

All NHS Service providers are required to continually review their services to ensure they meet the requirements of the NHS programme to support Quality, Innovation Productivity and Prevention (QIPP).

The key financial implications of the proposed decision include the planned efficiency in the overhead cost for estates and facilities for the Denham Unit from 28% of total budget to 10% of total budget in line with Trust standards.

Performance Issues

1. Impact on Council Priorities

The key Council priority that is impacted on by the performance of the Denham Unit relates to making a difference for the vulnerable. The delivery of intermediate care provided by the Denham Unit at CMH will enable the more effective prevention of unnecessary admissions to acute care of vulnerable patients through an improved environment, thus better supporting the higher level acuity and dependency patients that the service now sees more frequently. In addition, the CMH site will support the improved facilitation of discharge of patients to be supported to be independent in the community.

2. Performance Indicators

Local or national performance indicators in relation to the Denham Unit that will be positively impacted upon through this proposal include:

a. Less than 2% of total number of occupied bed days due to delayed transfers of care attributable to NHS (Current performance 5%)

b. Occupancy of greater than 90% of total number of bed days in the Denham Unit (Current performance 96%)

3. Current performance against indicators

Current performance against the above targets is bracketed above. LNWHT forecasts that with the relocation of the Denham Unit on to the CMH site that performance against delayed transfers of care attributable to NHS will be in line with performance requirements from the month immediately after the move.

4. Will the proposal require the performance target(s) to be changed? If that is not yet possible, when will the new target(s) be set?

The move of the Denham Unit will not require performance targets to be changed and is likely to support improvement in performance as outlined above.

5. What impact, positive or negative, will the proposal have on assessments of the Council by external regulators (such as Ofsted, Care Quality Commission, Audit Commission)?

The proposal above will not have a direct impact on assessments of the Council by external regulators.

6. What aspects of the Comprehensive Area Assessment Organisational Assessment will be affected

N/A

7. What impact is there on resident outcomes that are delivered either by partners or by joint working with partners?

The primary impact on resident outcomes will be to:

- Better support residents to remain in their preferred place of care
- To maintain residents' independence in the community
- To avoid unnecessary admission to acute care

8. What would the effect be, in relation to all of the above, if the proposal did not go ahead?

If the recommendations were not to be adopted the effect would be that service targets and quality indicators would not be met and that patient care and quality of life would suffer as a result due to the increasing limitations of the physical environment and changing needs of patients.

Environmental Impact

The relocation of the Denham Unit includes measures that support the delivery of the Council's climate change strategy. The main environmental impact aspects to consider in relation to the Denham Unit relocation proposal include:

- **Energy:** Reduction of the number of community bases will realise efficiencies in energy consumption. More efficient use of resources in terms of energy consumption
- **Traffic and transport:** The recommended transfer to CMH will utilise existing efficient public transport routes to and from CMH to promote access and encourage use of public transport.

A formal Environmental Impact Assessment has not been considered necessary for this proposal.

Risk Management Implications

Risk included on Directorate risk register? Yes – risk assessments have been undertaken particularly with respect to infection control and these are reflected in the LNWHT Community Services Risk Register.

Key risks of existing location include:

- Potential infection control issues leading to patients having to be readmitted to acute care due to infection
- Denham Unit not being responsive to whole system demand for winter 2015/16 by not being able to maintain contracted levels of bed occupancy
- Financial risk to service through inefficient use of resources and high cost of occupancy and site thereby not offering best value for tax payers.

The key current controls in place to mitigate the risks above include:

- Planned relocation of the Denham Unit to the CMH site
- Regular hand hygiene and infection control audits
- Working with the current landlord to support meeting NHS quality standards.

Opportunities associated with the proposal include:

- Better utilisation of LNWHT resources to deliver the service from an existing site with available bed space
- Enhanced transfer of patients to community care through provision of the service on an existing hospital site
- Better utilisation of onsite estates and facilities resources and infrastructure at CMH
- Well-developed infrastructure at CMH site, e.g. ICT, power, heating systems.
- On-site back-up medical support, diagnostic, laboratory and pharmacy services

Equalities implications

Was an Equality Impact Assessment carried out? No

If no, state why an EqIA was not carried out below:

An Equalities Impact Assessment will be undertaken as part of the staff consultation process.

Council Priorities

The proposal incorporates and addresses the administration's priorities through:

- **Making a difference for the vulnerable:** By ensuring that the care provided by LNWHT is provided from a location that best supports the most vulnerable patients that are most in need through addressing the identified service quality and infrastructure issues to enable patients to remain independent in the community
- **Making a difference for communities:** Through ensuring that the long term plan for the location of the Denham Unit in Harrow is considered in relation to the best possible facilities available
- **Making a difference for families:** The Denham Unit relocation considers the plan for meeting the needs of Harrow patients, relatives and carers accessing the Denham Unit service.

Section 3 - Statutory Officer Clearance

Not Required

Ward Councillors notified:	**NO**

Section 4 - Contact Details and Background Papers

Contact: Mary Jamal, Community Services Director for Brent and Harrow, LNWHT
Phone: 020-8966-6374

Background Papers: Nil

REPORT FOR: **HEALTH & SOCIAL CARE SCRUTINY SUB-COMMITTEE**

Date of Meeting:	26th October 2015
Subject:	Harrow Local Safeguarding Adults Board (LSAB) Annual Report 2014/2015
Responsible Officer:	Bernie Flaherty (Director, Adult Social Services)
Scrutiny Lead Member area:	Councillors Margaret Davine, Performance Lead Member & Chris Mote, Policy Lead Member
Exempt:	No
Wards affected:	All
Enclosures:	Appendix A - Harrow Local Safeguarding Adults Board Annual Report 2014/2015

Section 1 – Summary and Recommendations

This report provides Scrutiny Committee Members with an overview of the Local Safeguarding Adults Board (LSAB) Annual Report for 2014/2015 which summarises safeguarding activity undertaken in that year by the Council and its key partners. It sets out the progress made against priorities, analyses the referrals received and outlines priorities for the current year (2015/16).

Recommendations:
Scrutiny Committee is requested to note the work that has taken place in 2014/15 and the action plan for 2015/16. Also to note that from April 2015 the Safeguarding Adults Board has been put on a statutory footing as required by the Care Act 2014.

Section 2 – Report

2.1 Introduction

This is the eighth Annual Report of the Local Safeguarding Adults Board (LSAB) and a copy is attached as an appendix for information.

2.2 The Care Act 2014

Under the Care Act 2014 the local Safeguarding Adults Board has 3 core duties. It **must**:

i. publish a strategic plan for each financial year

- *the Harrow LSAB has a 3 year strategic plan for 2014 – 2017*

ii. publish an annual report

- *Harrow LSAB's 7th Annual Report (for 2013/2014) was presented to the Council's Scrutiny Committee in July 2014. This 8th report for 2014/2015 will go to a Scrutiny meeting on October 26th 2015*

- *each partner organisation represented at the LSAB presented the Board's Annual Report for last year at their Executive level meeting or equivalent*

- *as in previous years, this report will be produced in "Executive Summary", "key messages for staff" and "easy to read" formats and will be available to a wider audience through the Council and partner agencies websites*

iii. conduct any Safeguarding Adults Reviews (SARs)

- *these will be carried out as required*

iv. have the following organisations on the Board – the Council; the local NHS Clinical Commissioning Group (CCG) and the chief officer of Police

- *the membership of Harrow's LSAB (as at 31st March 2015) is shown in Appendix 5 and their attendance record is shown at Appendix 6*

2.3 Management Information/statistics

The full set of statistical information is at Appendix 1 of the attached report.

Headline messages – safeguarding adults

Previous annual reports have compared Harrow's performance against the national figures. However with the introduction of the new data set (the SAR – Safeguarding Adults Return), this opportunity has reduced – the level of detail is significantly less, reducing the usefulness of the comparison and the first year was experimental and therefore potentially unreliable. This section therefore provides the Harrow position last year with commentary based on the last set of national data and local intelligence:

- 1,227 alerts compared to 1003 in 2013/14, represented a growth of 22% locally. A growth in number remains positive and suggests that briefing sessions, publicity and training events are being successful in raising awareness of the issues
- 51% of Harrow alerts were taken forward as referrals (629 referrals), compared to 62% in 2013/14. It is difficult to be sure what percentage of alerts should meet the threshold for investigation although it certainly would not be 100%. Given the high increase in alerts it is possible that quite a significant percentage are dealt with by other means e.g. information/advice, care management or "root cause analysis" for pressure sores. As previously, both internal and external file audits continue to check that appropriate alerts are being taken forward to the referral stage
- repeat referrals in Harrow increased slightly from 10% in 2013/14 to 18% in 2014/15. The last known national figure was 18%, so Harrow is now in line with other boroughs. As stated in previous reports, too high a figure suggests that work is not being done correctly or thoroughly first time around, so this is an important indicator and one the Board will want to continue to monitor closely. The most recent independent file audit (for cases completed between September 2014 and March 2015) looked at repeat referrals and with one exception found that they were all for a new concern, which is reassuring
- completed referrals in Harrow (88%) are now broadly in line with the last available national figure of 81%. The safeguarding adults team in the Council tracks cases very carefully to ensure that there is no "drift", however the introduction of Making Safeguarding Personal has slowed down the timescales because the user is in control of dates and venues for meetings etc
- in Harrow the female: male referral ratio at the end of 2014/15 was 65:35 which is very close to the last known national position of 61:39
- referrals for older people decreased slightly from 383 in 2013/14 to 363 in 2014/15, even so they remain the highest "at risk" group
- for adults with a physical disability the figure in Harrow last year was 53% compared to 66% in 2013/14. As indicated in last year's annual report it is important to note that in the statistics (as required by the Department of Health/ NHS Information Centre), service users (for example) who are older but also have a physical disability are counted in both categories.

It is therefore quite difficult to form a view about risks to younger adults whose primary disability is physical or sensory. The last national figure was 51%, so Harrow is now closer to that position

- mental health referrals increased slightly from 81 (13%) in 2013/14 to 103 (16%). This is still some distance away from the last national figure of 24%. Given that the main hospital site is located in Brent, it is possible that more in-patient statistics are counted in their data than in those generated by Harrow
- in Harrow the referral figure for people with a learning disability in 2014/15 was very slightly lower at 14% (88 cases) compared to 15% in 2013/2014. This remains lower than the last available national figure of 19%
- it is pleasing to note that the alerts from "BME" communities rose last year to 46% from 34% in 2013/14 – which is much more in line with the makeup of the Harrow population. The referral figure was 44% which is also positive, as it suggests that a proportionate number of alerts are progressed and people from "minority" communities are not being disproportionately closed before the investigation stage
- statistics showing where the abuse took place in Harrow remain broadly similar to 2013/14, with the highest percentage being in the service user's own home (61%) and 21% in care homes (long term and temporary placements). It is positive that last year's slight reduction in referrals from care homes has been sustained and at the time of writing this report there are no homes where a formal embargo is in place. Figures in other settings remain small e.g. 2% in an acute hospital (13 cases) and 5% in supported accommodation (30 cases)
- allegations of physical abuse (28%) and neglect (at 23%) were the most common referral reasons last year. The slight reduction in neglect cases (29% in 2013/14) is likely to be due to a different approach taken last year with pressure sores i.e. a root cause analysis being completed by NHS staff before a decision about the need for a safeguarding investigation was taken
- financial abuse (20%) and emotional/psychological abuse (22%) are the other significant figures which have each reduced by one percentage point
- in Harrow, social care staff e.g. "domiciliary care workers" (20%); "other family members" (30%) and "partner" (8%) were the most commonly alleged persons causing harm – these figures being very similar to those in 2013/14
- given the numbers of training and briefing sessions undertaken in recent years, it is always interesting to look at the source of alerts and this is the first time (following a request from the LSAB) that year on year comparison has been possible. Last year (as in the previous year) the highest number (20%) were from social workers/care managers. The other sources were: primary health care staff (12% - a small reduction on 2013/14); residential care staff (8% - also a small reduction on 2013/14); family (9% - a 1% reduction on 2013/14); secondary health care staff (16% - a 7% increase on 2013/14); mental health staff (1% - an 8% reduction); Police (5% - a 2% increase) and family/friend/neighbour (10% - a 2% reduction)

- outcomes in Harrow for the person alleged to have caused harm in relation to criminal prosecutions/Police action compared to the 2013/14 statistics of 10% have improved again slightly in 2014/15 to 12%. This indicates that the focus given to this area by the safeguarding adults team supported by the Police is positive, however progress is slow and work will need to continue in 2015/16
- outcomes for the adult at risk remain similar to previous years with the highest statistic being "no further action" at 23%.
  The other outcome areas include: increased monitoring (12%); community care assessment and services (12%); management of access to perpetrator (6%); moved to different services (5%); referral to MARAC (2%); referral to advocacy (2%); referral to counselling or training (2%); management of access to finances (2%); application to Court of Protection (1%). All figures are broadly similar to 2013/14, with the exception of a significant reduction in "no further action" which suggests that more creative outcomes are being identified for victims

Headline messages - Deprivation of Liberty Safeguards (DOLS)

This is the third year that the LSAB Annual Report has included a full set of statistics for use of the Deprivation of Liberty Safeguards (DoLS). The use of these safeguards is important in the Board's oversight of the prevention of abuse and as they are relevant for some of the most vulnerable people known to local services (and those that are placed out of borough), the LSAB needs to be reassured that they are carefully monitored.

There were 384 requests for authorisations last year (an increase of 370 on the previous year) of which 304 were granted. The very large increase followed the "Cheshire West" Supreme Court ruling in March 2014 which significantly changed the criteria requiring that any individuals meeting the "acid test" be assessed. There were 16 requests from hospitals compared to 5 in 2013/14.

It is now the case that anyone living in a care home or hospital without the mental capacity to consent to reside there and receive the care/support/treatment they may need, could be eligible for a DoLS authorisation.

Summary/Actions Required

In the majority of the performance statistics above, the Harrow position mirrors the last available national data and/or is broadly in line with the 2013/14 position. In some important areas e.g. Police action/criminal prosecutions; mental health referrals and alerts/referrals from BME communities, there was some improvement. Given that these were areas prioritised by the LSAB for 2014/15 this is a very positive outcome.

The action plan in this report (year two of the LSAB Strategic Plan 2014 – 2017) includes objectives to address the key messages from the statistical analysis.

2.3 Making a Difference – (progress on objectives for 2014/2015)

This section of the annual report looks at what difference the work of the LSAB made last year by reviewing progress on the priorities agreed for 2014/2015, as set out in the annual report for 2013/2014.

Theme 1 - Prevention and Community Involvement

The LSAB is confident that prevention of abuse of adults at risk is a high priority in Harrow

The LSAB's prevention strategy 2014 – 2017 ("Promoting Dignity and Prevention of Abuse") was formally agreed at the Board meeting in March 2014. 2014/15 was the first year of implementation which built on the work done from the previous plan. Examples of work in this area include:
Care providers ran events to mark Dignity Awareness Day (February 2015).
World Elder Abuse Awareness Day 2014 was marked with a Best Practice Forum on dignity and respect which was attended by 70 staff from a range of local organisations.
The Safeguarding Adults Services attended 4 of the "Safer Streets" events in 2014/15, speaking with members of the public about community safety issues for vulnerable people. Booklets and information were handed out, with the most popular being "The Little Book of Big Scams" produced by the Metropolitan Police and the Home Office.

Outcomes:

There were 61 alerts raised by friends/neighbours and family last year – and it is hoped that sustaining the numbers from the previous year was achieved as a result of the above activities.

Ensure effective communication by the LSAB with its target audiences

A formal Communications Plan for the LSAB was approved by the Board at the March 2015 business meeting. It aims to ensure that its target audiences across the whole community know about abuse and how to report it and that resources are used for publicity and awareness related events in the most time/cost efficient ways.

The LSAB's newsletter which commenced in 2013 continued throughout last year aimed at keeping all relevant individuals and organisations up to date with its work and any key issues that needed to be highlighted. The editions published (September and November 2013; January and March 2014) included topics such as: making safeguarding personal; statistical information; DoLS; loan sharks; Dignity Action Day; Fire Safety; Care Act; LSAB annual report 2013/14 and training information.

The Safeguarding Adults Service attended a wide range of community based events last year to raise awareness. This included several Safer Streets days (see above), an information event for older patients at the Elliott Hall primary care centre; Neighbourhood Champions briefings; and the "keep safe and well" event at Choices for All.

Outcomes:

The referrals from "BME" communities increased last year to 42% (44% of alerts) which is much more in line with the local demographic makeup of the borough.

The very positive arrangements between the Safeguarding Adults Service and the local Fire Service continued last year with 105 referrals for free home fire safety checks (an increase of 45 on the previous year).

Safeguarding Adults priorities are clearly referenced in wider community safety strategies e.g. Domestic Violence

Briefing sessions have been held for 16 more of the borough's Neighbourhood Champions (230 were briefed in 2013/14) who are the "eyes and ears" of the community on their individual street.

As in previous years, the safeguarding adults' contribution to the Council Tax leaflet (which goes to every household in the borough) featured "being a good neighbour", giving the example of distraction burglary and asking residents to be aware of vulnerable people in their street that might be targeted.

Contributions continued from the Safeguarding Adults Service to the Multi-agency Risk Assessment Conference (MARAC – domestic violence focus); Multi-agency Public Protection Arrangements (MAPPA – public safety focus); Prevent (prevention of terrorism focus), and Anti-social Behaviour Group (ASBAG – anti social behaviour focus) - ensuring effective information sharing and communication where vulnerable adults are victims or perpetrators.

Outcomes:

For Operation Conker in September 2014, the Harrow Police were interviewed and answered questions from the public on local community radio about the campaign which was focused on anti-burglary products and making your home looked lived in. The interview included reference to the most vulnerable people in the borough and related safeguarding implications.

There is evidence that the Harrow LSAB's work is influenced by user feedback and priorities

The independent social worker (who interviews randomly selected service users after the safeguarding investigation is concluded) continued last year to ask whether people knew how to report abuse and understood what would happen next. She reported that the majority of users were very happy with the outcome of the investigation. Staff continue to issue the easy to read publication "what happens after I report abuse?" however some people still reported being unclear about the process. New approaches under the "Making Safeguarding Personal" project will embed even further the requirement to start the process being clear about the user's views and to check throughout that they understand what's happening.

Service users attended the LSAB Annual Review Day again last year. They presented a DVD about what was important to them in keeping safe and provided challenge to Board members:

"we are frightened to talk to the Police"

"there is bullying and swearing at the Harrow Bus Station so it's a scary place"

"we are worried about keeping safe on Facebook and about cyber bullying"

"we are worried about nasty messages on mobile phones"

"why haven't more people with mental health difficulties reported abuse?"

Outcomes: as a result the LSAB did the following:

- there was a "Keep Safe in Harrow" session at Choices last December. 70 people came and the Borough Police Commander (Simon Ovens) was there with some of his officers. He gave lots of advice about keeping safe e.g. that the Police have sophisticated technology and excellent links with mobile phone companies, so if users got nasty messages they should keep them and tell the Police. Lots of people talked to the Police at the event and afterwards said that they wouldn't feel so worried about asking a Policeman for help

- more work has been done to set up a Harrow Safe Place scheme. Choices For All students are helping and are visiting shops, churches and cafes near the Bus Station jointly with the local Police (as the first priority area) asking them to sign up

- there were more articles in "News and Views" e.g. about fire safety and keeping safe on-line

- CNWL Mental Health NHS Trust carried out a lot of work last year to get information out for people to look at. 3% more people reported abuse last year than the year before

Theme 2 – Quality and Performance Review

The LSAB oversees effective practice and ensures continuous improvement

Performance management reports were presented to the LSAB at all of its meetings in 2014/2015. Following the Peer Review recommendations members were asked to provide input to these reports, however there is still more to do in this regard.
A provider concerns section was added to the performance reports last year so that important information could be shared amongst the LSAB's member organisations.

Peer Review
The Peer Review challenge of safeguarding adults work in Harrow was commissioned by the Council with the full support of the Local Safeguarding Adults Board. This had concluded in 2013/14 with the outcome "good to great", so last year focused on implementation of the action plan to address its recommendations.

Outcomes:

As a result of implementing the Peer Review recommendations examples of outcomes include:

- the Access Harrow "first contact" message for people ringing with concerns was simplified with a specific choice for safeguarding adults

- a "mystery shopping" exercise was commissioned by the LSAB which was carried out by users (supported by Mind in Harrow) in September 2014 with feedback provided to both Access Harrow and CNWL

- more briefing sessions took place at GP surgeries, although this did not result in a further increase in alerts from primary care services

File Audit

Both internal and external (independent) audits of casework continued in the Council's Safeguarding Adults and DoLS Service during 2014/15 with headline massages presented to the LSAB. A total of 105 cases were reviewed with the key focus being on learning from the audit findings and providing feedback to relevant front-line staff and managers.

Outcomes:

Changes were made to the multi-agency training programme and also to the specific sessions for front-line staff. For example, a bespoke course on "unwise decisions" made by vulnerable adults with capacity who choose to put themselves at high risk was commissioned and delivered by a specialist trainer.

Statistical data improves understanding of local patterns enabling improved planning of responses to allegations

The LSAB has received statistical reports at each of its meetings, including the full year position for 2014/2015 at its Annual Review/Business Planning Day this June. In addition, the new Strategic Plan for 2014 – 2017 included trend analysis looking back over the previous 3 years and all reports included comparison with the national position wherever possible.

Some targeted briefing sessions took place, including for groups not previously visited before including: an Asian day centre for older people; Age UK volunteers; RSPCA staff and volunteers; the Wiseworks Centre for people with mental health difficulties; MIND in Harrow users and volunteers.

Outcomes:

On-going analysis by the LSAB of relevant statistical information has enabled adjustments to be made to training events and also to briefing sessions. The most up to date comparisons with the national data shows a positive picture for the work in Harrow with areas identified for future work covered in the action plan at section 5 of the attached report.

Theme 3 –Training and Workforce Development

The LSAB is confident that the local workforce is competent in relation to safeguarding adults' practice – with particular focus on learning from file audits and management reviews e.g. use of the Mental Capacity Act

Multi-agency training remains a high priority for the LSAB. The existing programme is competency based.

As a supplement to the formal training programme, the Safeguarding Adults Service also ran briefing sessions across a range of agencies, offering most at the organisation's premises. Full details of the training statistics are at Appendix 2 of the attached report.

Headline messages

- a total of 2143 people received some training in 2014/2015

- 1,115 staff received formal training – this was the same level as in the previous year - the breakdown of formal training was: 224 Council staff (an increase of 47 from 2013/14); 67 NHS staff (an increase of 1 from 2013/14); 9 "other statutory" staff including the Police (a decrease of 9 from 2013/14); 565 private sector staff (an increase of 296 from 2013/14) and 250 voluntary sector staff (an increase of 156 from 2013/14)
- a refresher was organised for elected Councillors and was attended by 35 individuals (an increase of 23 on the previous year)
- 1,028 people attended sessions run by the Safeguarding Adults Service including some new groups e.g. RSPCA staff/volunteers and local Dentists
- a total of 209 staff attended 4 multi-agency best practice forums in 2014/15 on "dignity and respect in care" for WEAAD 2014; "Keep Safe and Well" (joint with the Police and Choices For All); "Recognising the Links" (joint with the LSCB and RSPCA); and "Unwise Decision Making/Mental Capacity"
- there was a 21% reduction in individuals booked on to formal training courses cancelling or failing to attend, a significant decrease following the LSAB decision to charge for non-attendance
- this was the third year for the e-learning course which allows some front line staff to access training that they might otherwise not be able to e.g. GP trainees. A total of 66 staff used the tool last year

Outcomes:

Each year the multi-agency training programme and Best Practice Forums are developed from the evaluation and experience of the previous year's sessions. They also cover the areas that successive independent audits of safeguarding cases and the Peer Review suggested for further improvements in staff knowledge and/or confidence. An on-going high priority was given to mental capacity training, and new topics included "train the trainer" so that organisations can run more in-house sessions themselves, and "what I need to know as the lead for my organisation?" – both being well received by attendees.

Theme 4 - Policies and Procedures/Governance

Ensure production of the LSAB Annual Report and presentation to relevant accountable bodies

Following its formal agreement at the LSAB annual review day in 28th June 2014, the report was presented to the Council's Scrutiny Committee in July 2014, the Health and Wellbeing Board in September 2014 and subsequently to all partner agencies' Executive meetings or equivalent

The LSAB Annual Report for 2014/2015 was formally agreed by the Board at its annual review/business planning event in June 2015. This day was facilitated by Dr Adi Cooper (a national lead for safeguarding adults) who had challenged the Board and found it had solid arrangements with no complacency and therefore was well placed to take on its statutory role.

Subsequently the LSAB annual report is being presented to the Council's Scrutiny Committee (October 26th 2015) and partner agencies' Executive meetings or equivalent.

Outcomes:

As in previous years, following the decision to sign off the annual report by the LSAB last June a "key messages for staff" version of the report was produced for the second time and an easy to read version was put on the Council's website – aiming to ensure that the Board's work is as accessible as possible to both staff and the public.

The general public is aware of safeguarding issues & the work of the LSAB

As stated earlier in this report, the Safeguarding Adults Service attended a wide range of community based events last year to raise awareness. This included several Safer Streets days (see above), an information event for older patients at Elliott Hall primary care centre; Neighbourhood Champions briefings; and the "keep safe and well" event at Choices for All. The information in the Council tax leaflet (pushed through every letter box) and the community radio coverage were further examples of the service trying to reach out to the general public. Other broader campaigns included articles in the Fire Safety magazine "fire is not the only danger you face" and an article in "Homing In" the Council's Housing Department newsletter for all tenants.

The safeguarding adults' website was kept up to date and has a section for easy to read information.

LSAB (jointly with LSCB) takes a "family first" approach to its work

The joint protocols developed in 2013/14 by the LSAB/LSCB sub-group and formally launched by the chairs of the 2 Boards in October 2013 were refreshed last year.

Work between the two Boards continued with (for example) a joint best practice forum on "recognising the links" at which the RSPCA presented information about the growing recognition of risks for children or vulnerable adults in homes where animals are abused and vice versa. Wherever appropriate, meetings where there are common issues are held jointly e.g. the bi-annual meeting with the London Ambulance Service.

Outcomes:

The independent/external file auditor reported again last year that workers in the safeguarding adults team were demonstrating confidence in a "family first" approach, stating that all the relevant (audited) cases had been appropriately referred to Children's Services. In the most recent audit there were also examples of good practice highlighted where joint work on complex cases had produced a more positive outcome for the user.

The LSAB has strategic oversight of local safeguarding adults work

Year one actions from the LSAB Strategic Plan 2014 – 2017 were implemented with an exception report at each Board meeting. This section of the annual report covers the work carried out and some of the outcomes achieved as a result.

Theme 5 – Partnership with the Local Safeguarding Children's Board (LSCB)

Common joint safeguarding needs are identified in terms of Domestic Violence and actions prepared to address gaps, including mapping key pathways to MARAC

Independent file audit last year also reviewed cases where domestic violence was a factor. The LSAB was reassured by the finding that referrals were being routinely made to MARAC and it is becoming much more common for a worker or manager from the Safeguarding Adults/DOLS Service to attend the meetings for specific cases. Some audited cases also recognised work done with both the Looked After Children's and Children with Disability Teams.

Outcomes:

Better outcomes for young adults in specific cases where joint work was effective.

The LSAB (joint with LSCB) takes a "family first" approach to its work

See above. In addition, a practitioner representative from the Council's Safeguarding Adults/DoLS Service and relevant NHS staff provide information for the daily MASH (Multi-agency Safeguarding Hub) meeting where threshold decisions about referred children are discussed. This ensures appropriate information sharing and therefore decisions are taken in the most informed way possible.

2.4 LSAB Objectives for 2015/2016

The LSAB's objectives for 2015/2016 build on those established the previous year and address the priorities identified in its new Strategic Plan for 2014 - 2017. The priorities include: specific projects to tackle wider community safety issues as highlighted by users (e.g. hate crime; safe travel on public transport; distraction burglary/doorstop crime; safe place scheme and home fire safety); to formally evaluate the multi-agency and single agency training programmes with a focus on outcomes for participants in practice; for the LSAB to agree an effective approach to fulfil its responsibilities for overseeing work on self-neglect; and to consider all possible areas for joint approaches with the LSCB e.g. in relation to safeguarding training, work with schools and sexual exploitation.

Section 3 - Financial Implications

The revenue cost of the Safeguarding Adults Service (and related activities e.g. publicity) is outlined in the Annual Report under the "LSAB Resources" section. The increased activity during 2014/2015 resulted in additional costs incurred by the Safeguarding Adults and DoLS Service, however this was contained within the overall adult social care budget.

The additional increase in cases (30%) already seen in 2015/16 following the introduction of the Care Act has required the Council to identify funds for an additional wte qualified social worker for the Safeguarding Adults Team.

As highlighted last year, the other financial implication arising from this report relates to the Supreme Court judgement in the DoLS work area.

There were 384 requests for authorisations last year (an increase of 370 on the previous year) of which 304 were granted. The numbers for 2015/16 are projected to be around 700 cases.

The average (direct) cost of an assessment is £430 (the assessment costs) however this does not factor in the office based administration and coordination (indirect) costs.

The Council has received a financial contribution for 2015/16 from the Department of Health (DoH) of £104K in recognition of the extremely high numbers of cases, however this is inadequate to cover the totality of the rising numbers so the Council has had to fund the remaining cost pressure. Whilst in previous years costs have been contained within the Adult social care budget, the increasing care cost pressures together with the reduced budget to deliver MTFS savings to contribute towards council budget gap are likely to influence the ability to contain these pressures moving forward.
It is also not clear at this stage whether the DoH grant is one-off or will be recurring in subsequent years.
The expectation is that the outcomes can be delivered within the annual financial envelope, however this continues to prove challenging where the pressures are demand led and of a statutory nature.

NB. It is important to note that there are statutory requirements to carry out DoLS assessments and the timescales in which they must be completed are set out under the DoLS framework i.e. that urgent referrals must be assessed within 7 days and standard authorisation requests within 21 days.

There is consequently no option but to process the cases as soon as they are referred to the Council, including use of independent staff where required (psychiatrists) or to meet resource gaps (availability of qualified Best Interest Assessors).

Section 4 - Performance Issues

The report is primarily concerned with performance and contains analysis of the Harrow LSAB statistics, both as they relate to the previous year and also to national data.

Section 5 - Environmental Impact

There is no environmental impact arising from this report.

Section 6 - Risk Management Implications

Risk included on Directorate risk register? Yes

Separate risk register in place? No

Potential risks:
Failure to ensure local safeguarding adults' arrangements are robust could lead to a serious untoward incident e.g. death of a vulnerable person. Failure to implement the statutory DoLS guidance could lead to a legal challenge about unlawful deprivation of a vulnerable person in a care home or hospital.

Section 7 - Equalities implications

The LSAB considers local safeguarding adults statistics at each Business Meeting and at its annual review/business planning event, with particular emphasis on ensuring that alerts (now "concerns") are being received from all sections of the community. The new Strategic Plan for 2014/17 has been developed such that the LSAB will monitor the impact of abuse in all parts of Harrow's community and will focus its awareness raising sessions in areas where low/no referrals have been received in the previous period. Safeguarding adults' work is already focused on some of the most vulnerable and marginalised residents of the local community and the 2014/15 statistics demonstrate that concerns are coming from all sections of the Harrow community.

Section 8 - Corporate Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

This report primarily relates to the Corporate priorities of:

- making a difference for the vulnerable
- making a difference for communities

Section 9 - Statutory Officer Clearance

Name: Donna Edwards (comments are included in section 3) Date: 3rd September 2015	x	on behalf of the* Chief Financial Officer

Ward Councillors notified:	**NO** - the report affects all Wards

Section 10 - Contact Details/Background Papers

Contact: Visva Sathasivam (Head of Adult Social Care)
(Direct Dial: 0208 736 6012)

Background Papers: Harrow Local Safeguarding Adults Annual Report 2014/2015

Harrow COUNCIL
LONDON

& our Partners,

Committed to
Safeguarding Adults

Harrow Local Safeguarding Adults Board (LSAB)

Annual Report

2014/2015

Harrow COUNCIL
LONDON

in partnership with:

HAD – Harrow Association of Disabled People – Enabling Potential

mind For better mental health

Harrow mencap Providing opportunity : promoting change

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Royal National Orthopaedic Hospital NHS Trust

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Ealing Hospital NHS Trust

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METROPOLITAN POLICE Working together for a safer London

Local Safeguarding Children Board

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Foreword

This is the 8th Annual Report published on behalf of Harrow's Local Safeguarding Adults Board (LSAB) and contains contributions from its member agencies. The Board coordinates local partnership arrangements to safeguard adults at risk of harm. This report details the work carried out by the LSAB last year (2014/15) and highlights the priorities for 2015/16.

Last year the LSAB built on the work done for the Peer Review by signing up for the national "Making Safeguarding Personal" (MSP) project. This work aims to ensure that users determine early on what they want from the safeguarding process and that we check with them throughout that they are as in control as they want to be. There is more information about MSP in this report and the LSAB will be checking that the agreed actions are progressed, so that even better outcomes can be achieved for service users.

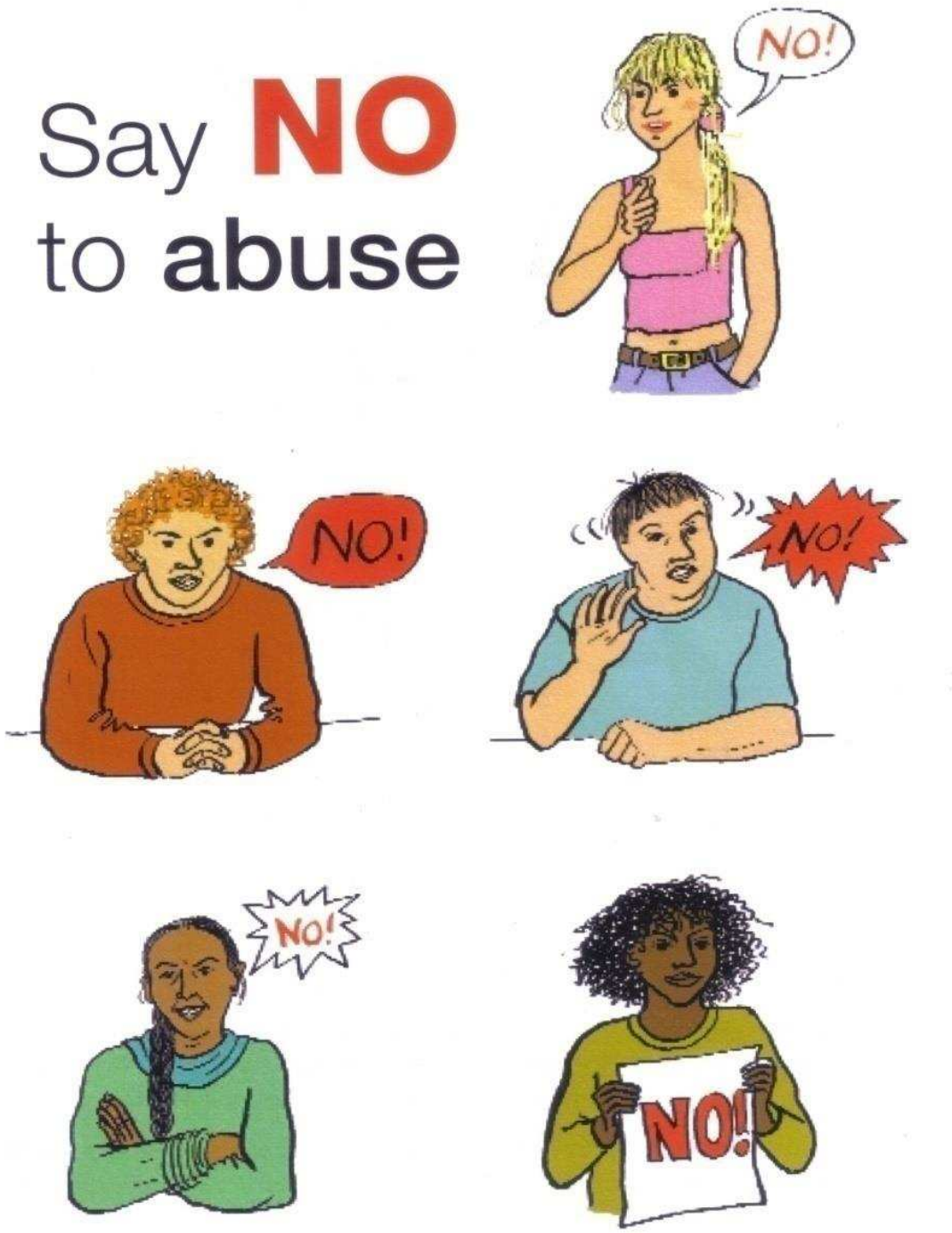
By the time this report is published the Care Act 2014 will have been introduced. One of its key requirements is that there is a local safeguarding adults board and it now has statutory status bringing it more in line with the equivalent Board in Children's Services. A summary of the Care Act requirements and the good progress already made in Harrow is covered later in this report.

There was a lot of excellent work done last year on the priorities that the LSAB had agreed were important. For example: we have run some more multi-agency best practice forums for staff, including an innovative event with the Local Safeguarding Children's Board and the RSPCA looking at the links between child/adult abuse and animal cruelty. The newsletter from the LSAB covered a very wide range of topics and discussion ideas and I hope that you continue to find it informative. We trained even more staff than in previous years and once again received a rise in alerts from people concerned that a vulnerable adult may be at risk of harm. I think this annual report demonstrates the difference that the Board's work has made to the lives of the most vulnerable people in the borough (see section 4) and trust you agree once you have read it.

Key priorities for the LSAB in the coming year include: a focus on self neglect now that it comes under the umbrella of safeguarding; learning about the new areas the Board is now responsible for e.g. modern slavery; and more prevention activities for the wider public. As ever, everything the LSAB does is to achieve its vision – "*that Harrow is a place where adults at risk from harm are safe and empowered to make their own decisions and where safeguarding is everyone's business".*

Bernie Flaherty

Director of Adult Social Services (Chair of the LSAB)



"Harrow is a place where adults at risk from harm are safe and empowered to make their own decisions and where safeguarding is everyone's business" (LSAB Vision)

SECTION 1 - INTRODUCTION

1. Introduction to the annual report

This Annual Report describes all the activity carried out by the partnership organisations that form the Harrow Local Safeguarding Adults Board (LSAB) to support the safeguarding of vulnerable adults during 2014/2015. It also looks ahead to the Board's priorities for 2015/16, including any that ensure the requirements of the Care Act 2014 are addressed.

1.1 The Harrow Local Safeguarding Adults Board (LSAB)

The Local Safeguarding Adults Board (LSAB) is chaired by Bernie Flaherty (Director – Adult Social Services, Harrow Council) and is the body that oversees how organisations across Harrow work together to safeguard or protect adults who may be at risk of significant harm, or who have been abused or harmed.

The LSAB takes its leadership role very seriously with appropriate senior management attendance from member organisations and (for the Council) the active involvement of the elected Councillor who is the Portfolio holder for adult social care, health and well-being. The list of members (as at March 31st 2015) is at Appendix 5, with their attendance record at Appendix 6.

1.2 LSAB Accountability

Under the Care Act 2014 the local Safeguarding Adults Board has 3 core duties. It **must**:

i. publish a strategic plan for each financial year

- the Harrow LSAB has a 3 year strategic plan for 2014 – 2017

ii. publish an annual report

- Harrow LSAB's 7th Annual Report (for 2013/2014) was presented to the Council's Scrutiny Committee in July 2014. This 8th report for 2014/2015 will go to a Scrutiny meeting on October 26th 2015 and the Health and Wellbeing Board as soon as possible after that date
- each partner organisation represented at the LSAB presented the Board's Annual Report for last year at their Executive level meeting or equivalent
- as in previous years, this report will be produced in "Executive Summary", "key messages for staff" and "easy to read" formats and will be available to a wider audience through the Council and partner agencies websites

iii. conduct any Safeguarding Adults Reviews (SARs)

- these will be carried out as required

iv. have the following organisations on the Board – the Council; the local NHS Clinical Commissioning Group (CCG) and the chief officer of Police

- the membership of Harrow's LSAB (as at 31st March 2015) is shown in Appendix 5 and their attendance record is shown at Appendix 6

1.3 "Pan-London" Procedures

In common with all London boroughs, the Harrow LSAB (and therefore all staff in its constituent organisations) is signed up to work within the "Protecting Adults At Risk: London multi-agency policy and procedures to safeguard adults from abuse" issued by the Institute of Social Care Excellence (SCIE) in collaboration with NHS London and the Metropolitan Police in January 2011. These procedures were followed last year and when the new set of Care Act compliant procedures are issued will be formally adopted by the LSAB.

1.4 Care Act 2014

Requirements under the Care Act replace the "No Secrets" guidance. The Harrow LSAB has considered its responsibilities under this legislation at two business meetings (see section 2.1 below) and the resulting actions are covered in section 5 – referenced as "CA".

1.5 A review of findings from the 2013-14 (NHS) Safeguarding Adults at Risk Audit Tool – self assessment as carried out by London Safeguarding Adults Boards

The Harrow LSAB considered this process at all its Business meetings last year. Recommendations specifically for Safeguarding Adults Board (SABs) were as follows:

- SABs should take account of findings and benchmark their own work against other London SABs to see where they might learn from others
- local partnerships should identify mechanisms for analysing information to assist early identification of safeguarding issues
- SABs should ensure lessons learnt from serious incidents and safeguarding adults reviews are disseminated
- to ensure information on adult safeguarding is accessible to all parts of the community recognising diversity
- to make use of the "Making Safeguarding Personal" resources to achieve an outcome focus

All these points are being addressed by the Board (see section 5).

"Harrow is a place where adults at risk from harm are safe and empowered to make their own decisions and where safeguarding is everyone's business" (LSAB Vision)

SECTION 2

LSAB Work Programme in 2014/2015

Section 2 – LSAB work programme 2014/2015

2.1 Harrow LSAB business meetings – work areas covered

The LSAB met on 4 occasions in 2014/2015 – three Business Meetings and an Annual Review/Business Planning Day. The following table lists the main topics discussed by the Board at those meetings – some being standing items (e.g. quarterly statistics); some were items for a decision (e.g. the new Communications Policy); some were for information/discussion (e.g. user views from the Keep Safe event); others were aimed at Board development (e.g. the Human Trafficking presentation), and there were also specific items providing challenge to the Board (e.g. user input to the annual review/business planning day). Some items (e.g. the Care Act implications and the NHS audit tool) were discussed at more than one meeting.

Prevention and Community Engagement

- User Engagement - feedback on progress with the Harrow Safe Place Scheme development and from the "Keep Safe" event held at Choices For All in December 2014 (item for information)
- Peer Review action plan – update on the Mystery Shopping exercise (item for information and decision)
- "Safeguarding is all about us" – user input to annual review/business planning day (item for challenge)
- Pressure sores – prevalence concerns and links to safeguarding adults (item for discussion)
- World Elder Abuse Awareness Day 2014 in Harrow – local arrangements agreed (item for decision)
- "Who is at risk" – fire prevention for vulnerable adults (item for information)
- Budget cuts and any impact on vulnerable people – (item for challenge)
- LSAB Communication Policy – agreed (item for decision)

Training and Workforce Development

- LSAB Training programme for 2015/2016 (item for information and decision)
- Feedback from Best Practice Forums e.g. “recognising the links” jointly with the LSCB and RSPCA in October 2014 (item for information)
- FGM – issues for the LSAB – for information (item for information and Board development)
- “Human Trafficking - Safeguarding Adults and Children (item for information and Board development)
- Personalisation and Safeguarding Adults (item for information and Board development)

Quality and Performance Review

- Peer Review action plan monitoring (item for decision)
- Quality assurance framework for safeguarding adults’ work (standing item)
- File audits – confirmation of each Board member organisation’s audit processes (item for information)
- Quarterly statistics – discussed and findings used by the LSAB to inform changes to the training programme and local practice (standing item)
- CNWL response to CQC review and update on new inspection approach (item for information)
- NHS audit tool for safeguarding adults – update (item for information)
- Pressure sores – update on NW London project (item for information)

Policies and Procedures/Governance

- LSAB Strategic Plan 2014/17– exception reports (item for discussion)
- The LSAB Annual Report 2013/2014 - discussed and formally signed off (item for decision)
- NHS self assessment framework for safeguarding adults and new audit tool (item for information)
- DBS checks for Councillors agreed by Council 12th June 2014 (item for information)

- Care Act 2014 – implications for safeguarding adults – recommendations/actions agreed (item for discussion and decision)
- Making Safeguarding Personal – action plan agreed (item for discussion and decision)
- NHS duties of candour and escalation (item for information)
- Metropolitan Police information sharing agreement (item for discussion)
- Escalation of concerns protocol (item for decision)

Joint work with the Local Safeguarding Children's Board (LSCB)

- LSCB independent audit (item for information)
- LSCB Annual Report (item for information)
- Special Education Needs Reforms (item for information)
- Joint Protocol between the LSAB and LSCB – agreed (item for decision)
- Child Sexual exploitation – LSCB feedback (item for information)

2.2 Management information (statistics)

The Board collates multi agency information on a range of adult safeguarding statistics in order to produce a management report. The report which is available at each business meeting is overseen by and discussed at the LSAB.

It attempts to identify trends in referral data and to provide accessible and useful statistics to Board members which can then be used to inform decisions e.g. identifying where awareness campaigns or training should be focussed.

The full sets of statistical information for safeguarding adults and DoLS services in 2014/15 are at Appendix 1.

Headline messages – safeguarding adults

Previous annual reports have compared Harrow's performance against the national figures. However with the introduction of the new data set (the SAR – Safeguarding Adults Return), this opportunity has reduced – the level of detail is significantly less, reducing the usefulness of the comparison and the first year was experimental and therefore potentially unreliable.

This section therefore provides the Harrow position last year with commentary based on the last set of national data and local intelligence:

- 1,227 alerts compared to 1003 in 2013/14, represented a growth of 22% locally. A growth in number remains positive and suggests that briefing sessions, publicity and training events are being successful in raising awareness of the issues
- 51% of Harrow alerts were taken forward as referrals (629 referrals), compared to 62% in 2013/14. It is difficult to be sure what percentage of alerts should meet the threshold for investigation although it certainly would not be 100%. Given the high increase in alerts it is possible that quite a significant percentage are dealt with by other means e.g. information/advice, care management or "root cause analysis" for pressure sores. As previously, both internal and external file audits continue to check that appropriate alerts are being taken forward to the referral stage
- repeat referrals in Harrow increased slightly from 10% in 2013/14 to 18% in 2014/15. The last known national figure was 18%, so Harrow is now in line with other boroughs. As stated in previous reports, too high a figure suggests that work is not being done correctly or thoroughly first time around, so this is an important indicator and one the Board will want to continue to monitor closely. The most recent independent file audit (for cases completed between September 2014 and March 2015) looked at repeat referrals and with one exception found that they were all for a new concern, which is reassuring
- completed referrals in Harrow (88%) are now in line with the last available national figure of 81%. The safeguarding adults team in the Council tracks cases very carefully to ensure that there is no "drift", however the introduction of Making Safeguarding Personal has slowed down the timescales because the user is in control of dates and venues for meetings etc
- in Harrow the female: male referral ratio at the end of 2014/15 was 65:35 which is very close to the last known national position of 61:39
- referrals for older people decreased slightly from 383 in 2013/14 to 363 in 2014/15, even so they remain the highest "at risk" group

- for adults with a physical disability the figure in Harrow last year was 53% compared to 66% in 2013/14. As indicated in last year's annual report it is important to note that in the statistics (as required by the Department of Health/ NHS Information Centre), service users (for example) who are older but also have a physical disability are counted in both categories. It is therefore quite difficult to form a view about risks to younger adults whose primary disability is physical or sensory. The last national figure was 51%, so Harrow is now closer to that position
- mental health referrals increased slightly from 81 (13%) in 2013/14 to 103 (16%). This is still some distance away from the last national figure of 24%. Given that the main hospital site is located in Brent, it is possible that more in-patient statistics are counted in their data than in those generated by Harrow
- in Harrow the referral figure for people with a learning disability in 2014/15 was very slightly lower at 14% (88 cases) compared to 15% in 2013/2014. This remains lower than the last available national figure of 19%
- it is pleasing to note that the alerts from "BME" communities rose last year to 46% from 34% in 2013/14 – which is much more in line with the makeup of the Harrow population. The referral figure was 44% which is also positive, as it suggests that a proportionate number of alerts are progressed and people from "minority" communities are not being disproportionately closed before the investigation stage
- statistics showing where the abuse took place in Harrow remain broadly similar to 2013/14, with the highest percentage being in the service user's own home (61%) and 21% in care homes (long term and temporary placements). It is positive that last year's slight reduction in referrals from care homes has been sustained and at the time of writing this report there are no homes where a formal embargo is in place. Figures in other settings remain small e.g. 2% in an acute hospital (13 cases) and 5% in supported accommodation (30 cases)
- allegations of physical abuse (28%) and neglect (at 23%) were the most common referral reasons last year. The slight reduction in neglect cases (29% in 2013/14) is likely to be due to a different approach taken last year with pressure sores i.e. a root cause analysis being completed by NHS staff before a decision about the need for a safeguarding investigation was taken
- financial abuse (20%) and emotional/psychological abuse (22%) are the other significant figures which have each reduced by one percentage point
- in Harrow, social care staff e.g. "domiciliary care workers" (20%); "other family members" (30%) and "partner" (8%) were the most commonly alleged persons causing harm – these figures being very similar to those in 2013/14

- given the numbers of training and briefing sessions undertaken in recent years, it is always interesting to look at the source of alerts and this is the first time (following a request from the LSAB) that year on year comparison has been possible. Last year (as in the previous year) the highest number (20%) were from social workers/care managers. The other sources were: primary health care staff (12% - a small reduction on 2013/14); residential care staff (8% - also a small reduction on 2013/14); family (9% - a 1% reduction on 2013/14); secondary health care staff (16% - a 7% increase on 2013/14); mental health staff (1% - an 8% reduction); Police (5% - a 2% increase) and family/friend/neighbour (10% - a 2% reduction)
- outcomes in Harrow for the person alleged to have caused harm in relation to criminal prosecutions/Police action compared to the 2013/14 statistics of 10% have improved again slightly in 2014/15 to 12%. This indicates that the focus given to this area by the safeguarding adults team supported by the Police is positive, however progress is slow and work will need to continue in 2015/16
- outcomes for the adult at risk remain similar to previous years with the highest statistic being "no further action" at 23%. The other outcome areas include: increased monitoring (12%); community care assessment and services (12%); management of access to perpetrator (6%); moved to different services (5%); referral to MARAC (2%); referral to advocacy (2%); referral to counselling or training (2%); management of access to finances (2%); application to Court of Protection (1%). All figures are broadly similar to 2013/14, with the exception of a significant reduction in "no further action" which suggests that more creative outcomes are being identified for victims

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Headline messages - Deprivation of Liberty Safeguards (DOLS)

This is the third year that the LSAB Annual Report has included a full set of statistics for use of the Deprivation of Liberty Safeguards (DoLS). The use of these safeguards is important in the Board's oversight of the prevention of abuse and as they are relevant for some of the most vulnerable people known to local services (and those that are placed out of borough), the LSAB needs to be reassured that they are carefully monitored.

There were 384 requests for authorisations last year (an increase of 370 on the previous year) of which 304 were granted. The very large increase followed the "Cheshire West" Supreme Court ruling in March 2014 which significantly changed the criteria requiring that any individuals meeting the "acid test" be assessed. There were 16 requests from hospitals compared to 5 in 2013/14.

It is now the case that anyone living in a care home or hospital without the mental capacity to consent to reside there and receive the care/support/treatment they may need, could be eligible for a DoLS authorisation.

Summary/Actions Required

In the majority of the performance statistics above, the Harrow position mirrors the last available national data and/or is broadly in line with the 2013/14 position. In some important areas e.g. Police action/criminal prosecutions; mental health referrals and alerts/referrals from BME communities, there was some improvement. Given that these were areas prioritised by the LSAB for 2014/15 this is a very positive outcome.

The action plan in this report (year two of the LSAB Strategic Plan 2014 – 2017) includes objectives to address the key messages from the statistical analysis.

2.3 LSAB Resources

As at 31st March 2015, the staffing of the dedicated Safeguarding Adults Service located in the Council is as follows:-

1 Service Manager (Safeguarding Adults and DoLS)

1 Safeguarding Adults Co-ordinator (DoLS)

1 Safeguarding Adults Co-ordinator (Strategy)

1 Team Manager

2 wte Safeguarding Adults Practice Advisers (senior practitioners)

6 wte qualified Social Workers

In addition to staff, there are ongoing costs for the multi agency training programme; best practice forums; publicity (posters/fliers/wallet cards); awareness/briefing sessions; independent file audit and administrative support to the LSAB etc.

The costs of these services are primarily borne by the Community, Health and Wellbeing Directorate within Harrow Council, with contributions totalling circa £25,000 p.a. from the four local NHS partner agencies (Harrow Clinical Commissioning Group; North West London Hospital Trust; Central and North West London Mental Health Trust and the Royal National Orthopaedic Hospital Trust).

Costs related to the time spent by partner agencies on LSAB activities e.g. attending meetings, facilitating staff release for training etc, are borne by the individual organisations.

"Harrow is a place where adults at risk from harm are safe and empowered to make their own decisions and where safeguarding is everyone's business" (LSAB Vision)

SECTION 3 – STATEMENTS FROM KEY LSAB PARTNERS

3. Statements from key LSAB partners

The following statements have been provided by some of the key agencies represented on the LSAB. The reports cover adult safeguarding issues from each organisation's perspective and some identify key priorities for 2014/2015.

3.1 Central and North West London Mental Health Trust (CNWL)

CNWL has continued to implement and develop strategies in relation to safeguarding which reflect its core values of:

- A strong user voice and empowerment, safety, respect and personal recovery.

  This year there has been a strong message from CNWL's safeguarding board to prioritise personalised approaches to safeguarding and the development of strategic partnerships with LSAB's. The appointment of a Harrow Borough Director with more local power including attendance at the Board reflects CNWL's emphasis on strategic partnerships and the priority given to safeguarding within the organisation.

Progress on Priorities for Prevention and Community Engagement

- the main initiatives in the Trust during 2014/15 has been around the Crisis Concordat and the Prevent agenda
- the Crisis Concordat has set a framework for work with other agencies particularly the emergency services
- it has put in place a framework to facilitate and improve understanding and liaison with the police. It gives a clear framework for mental health to work with the police on crime prevention initiatives
- the concordat also looks at the relationships with the fire services. There have been local meetings in Harrow to ensure the fire safety messages get through to mental health service users and to raise awareness amongst mental health service users of the availability of freely installed fire alarms from the local fire services. This included reminding service users that the service was not just for older people but for adults with long term mental health conditions
- CNWL safeguarding initiatives include implementation of the prevent agenda and a Trustwide programme of training and awareness has been undertaken in 2014/15

Outcomes For Training and Workforce Development

- the Trust has mandatory safeguarding adults training for all staff
- initiatives on sharing of information with other agencies to ensure awareness through the Trust of the policies to ensure relevant information including safeguarding concerns and the definition of "need to know" is fully disseminated

- improved supervision and support mechanisms for staff who whistle blow
- all job descriptions clearly identify staff's responsibilities in safeguarding adults at risk.
- the Trust training plan includes a full range of safeguarding adults training including investigator and safeguarding adult's manager training.

Outcomes For Quality and Performance Review

- during 2014/15 the Trust implemented the policy of recording all adults safeguarding incidents on Datix – the Trusts incident reporting system. This puts adult safeguarding on the same footing as other incidents. It gives a clearer recording system and improves the ability of the organisation to track and monitor safeguarding incidents.
- internal random auditing has continued throughout the year
- a mystery shopping exercise was undertaken. This identified some gaps in the response of first contact and admin staff knowledge which has led to a programme of training which has just been completed
- locally we are mid way through our first external audit and are awaiting the results
- figures for safeguarding activity in mental health services remain below the national average
- this is partly related to recording challenges with JADE system
- the use of Datix will improve this and it is expected using Datix will overcome these issues

Outcomes For Policy Procedures and Governance

- Ann Sheridan, CNWL Safeguarding Lead has confirmed the Harrow LSCB report was presented to the Trust at board level
- the Trust Head of Social Work and Social Care reports on safeguarding to the board. The Trust also has a named doctor
- the Trust hold a quarterly adult safeguarding group with strategic and partner agency representation to review and oversee the implementation within the Trust of local and national guidance. The meeting also looks at trends, reviews complex case work issues and shares lessons learnt from incidents and reviews
- with the CNWL restructure into divisions, Jameson Division also has a Safeguarding meeting
- locally the Borough director has safeguarding as a standard agenda item on the monthly Senior Management Team meetings
- safeguarding is integrated into the quality monitoring procedures and reviews of complaints and incidents with a recently established separate meeting to look at any emerging themes

Outcomes for Joint work with the LSCB

- the social work lead, Mark Hall-Pearson (Senior Professional Lead) represents the local services on the LSCB/LSAB sub group. Catherine Knights represents the Trust at a strategic level at that meeting
- Mental Health services are represented on the LSCB Quality Assurance sub group and are part of their audit processes
- the outcome of this audit process is fed into the monthly senior management team meetings
- regular supervision sessions are held on child protection matters with input from CAMHS colleagues
- during the last year staff have attended “think family training”

Priorities

- personalisation of the safeguarding process
- implement the outcomes of the safeguarding audit
- further development of the Prevent agenda
- evaluate the impact of recording of safeguarding adults incidents on the Datix system and its impact on numbers
- reflect on the low number of referrals and identify strategies for ensuring all safeguarding matters are picked up
- review the implementation of DOLS and MCA. To ensure practice reflects the law

3.2 Harrow Mencap

Harrow Mencap continues to support a zero tolerance approach to safeguarding and feels the best way to show its commitment is to actively promote the rights of people with learning disabilities and work in partnership with all agencies and individuals to raise awareness.

Outcomes for Prevention and community Development

- with our partners in Brent Mencap we have delivered a series of workshops on Hate Crime to people who use our services
- provided advocacy support for 20 individuals who were subject to safeguarding alerts ensuring their voice was heard in the process of protecting them.
- provided staying safe workshops for young people (aged 18-25) with learning disabilities
- as part of our partnership with other NWL Mencaps we have delivered quality checks on services for older and disabled people and have worked with providers on what we have found

Outcomes for Training and Workforce Development

- 4 members of staff undertook Safeguarding "Train the Trainer" training this enabled us to ensure all staff have basic awareness and refresher training
- 3 Members of staff have undertaken " safeguarding lead training"
- all Staff receive basic awareness training as part of their induction
- safeguarding is discussed at every team meeting
- safeguarding incidents are critically reviewed so staff can learn from the process

Outcomes for Quality and Performance Review

- we have increased numbers of safeguarding leads to four to ensure all staff have access to a safeguarding lead when required
- safeguarding leads meet regularly to review incidents and response to incident so any barriers are identified and addressed

Outcomes for Governance

- safeguarding is on agenda for every board meeting so the board are aware of any issues
- we have appointed a trustee with responsibility for safeguarding

Priorities for 2015-16

- ensure that all staff are aware of their responsibilities under the Care Act (2014)
- continue to work with people with learning disabilities on what being safe means to them and how to keep safe
- to continue to campaign to ensure that the rights of people with learning disabilities are upheld

3.3 MIND in Harrow

Mind in Harrow is firmly committed to Safeguarding Adults in partnership with Harrow Council, NHS, police and independent sector organisations with a particular focus on adults at risk owing to their mental health.

Outcomes for Prevention and Community Engagement

- contributed to safeguarding prevention by offering support and information, in conjunction with Harrow Council Safeguarding Team and CNWL NHS Foundation Trust, to people with mental health needs who have reported to us that they may be at risk of abuse or mistreatment
- increased community engagement and contributed to safeguarding prevention through the Chief Executive being a Trustee of Harrow Equalities Centre, which runs a Hate Crime project
- promoted safeguarding prevention by raising during the Council's Take Part consultation the impact if all funding or substantial funding is cut to the voluntary sector organisations, including our representation on LSAB

Outcomes for Training and Workforce Development:

- increased our staff awareness of safeguarding procedures through implementation of our policy that all our new employees are required to undertake the Harrow Council introduction to safeguarding training course.
- increased our volunteer and mental health service user representatives' awareness of safeguarding procedures through training delivered by the Harrow Safeguarding Team/Freelance trainer three times a year.
- increased staff awareness of the new requirements of the Care Act 2014 by staff attendance at Council training in early 2015.

Outcomes for Quality and Performance Review:

- increased awareness of mental health safeguarding issues from a voluntary sector perspective through our Chief Executive's attendance at Harrow Multi-Agency Safeguarding Adults Board meetings 2014-15, the Harrow LSAB away day in 2014 and Mind in Harrow representation at user engagement and governance LSAB subgroup meetings.
- contributed to partner quality assurance through Mind in Harrow User Involvement Project coordinating with Harrow Safeguarding team to conduct a 'Mystery Shopping' exercise with CNWL mental health community teams in the autumn of 2014, which has resulted in learning.

Outcomes for Policies and Procedures/Governance:

- improved Child Protection Policy through our annual review, incorporating guidance on identifying children at risk of exploitation.
- improved our Safeguarding Adults at Risk Policy by incorporating an explanation of the new Care Act 2014 requirements for safeguarding adults at risk and the new Prevent legislation.
- improved our Board of Trustees awareness of current local safeguarding issues through our Chief Executive's presentation of LSAB Annual Report 2013-14 of performance and planned actions 2014-15 to our October 2014 Board meeting.

Outcomes for joint work with the LSCB ("think family"):

- increased our staff awareness of safeguarding procedures by our policy that all new senior staff and casework staff are required to undertake Harrow Council introduction to safeguarding children training session.
- improved our management knowledge of current good practice through our Chief Executive and Finance & Operations Manager attending the Harrow Council 'Safer Recruitment' training day in June 2014.
- encouraged improved coordination between Harrow adult mental health safeguarding service lead and child protection services for situations raised with us where the alleged perpetrator is someone experiencing mental health problems.

Priorities for 2015/2016:

In addition to continuation of Mind in Harrow's actions and outcomes for 2014-15:

- contribute to partner quality assurance through Mind in Harrow User Involvement Project coordinating with Harrow Safeguarding team to conduct a second 'Mystery Shopping' exercise with CNWL mental health community teams.
- continue to feedback our learning from safeguarding alerts raised via Section 75 Agreement with CNWL NHS Foundation Trust for people experiencing mental health problems.

3.4 Age UK Harrow

Age UK Harrow is firmly committed to safeguarding adults and believes that all have the right to live free from abuse of any kind. Age or circumstances should not have any bearing or effect on this basic right.

Outcomes for Prevention and Community Engagement

- WEAAD: 16th June 2014

On this day, Age UK Harrow organised outreach in the following places:- Tesco, Libraries, Red Brick Café, St Georges Shopping Centre, Northwick surgery, Enderley Road clinic, Wealdstone clinic, Thomas Hewlett house, Watkins House, Milmans Centre, Princess Alexandra Home, Civic Centre, Knights Court Nursing Home, Harrow Weald Park, Swaminarayan Temple Stanmore, Stanmore Synagogue, Northwick Park Hospital - all wards.

Staff and volunteers gave out information on elder abuse awareness and how to report it. The feedback we got was fantastic as we reached out to more people by being out on the ground giving out information. Age UK Harrow had closed the office on the day to enable all staff and volunteers to take part in raising awareness about elder abuse.

- on-going articles on safeguarding in the newsletter to remind members about various abuse

Outcomes for Quality and Performance Review

- Age UK Harrow has contributed to quality and performance review through our Chief Executive, Avani Modasia, attendance at Harrow Multi-Agency Safeguarding Adults Board meetings, Harrow LSAB away day in 2014

- all staff now more aware of procedures internally on reporting safeguarding issues. Made 4 direct safeguarding referrals

Outcomes for Policies and Procedures/Governance

- Local Safeguarding Adults Board is standing agenda item at AUKH Board meetings
- as a result of incident introduced procedures to rotate volunteers on an annual basis for our befriending service
- we have continued to implement pan London Procedures
- worked to ensure production of the LSAB Annual Report

Outcomes for Training and Workforce Development

- staff continue to attend basic awareness course. Refresher training is also attended where appropriate. New dates are also being awaited for new staff
- we continue to access training that is provided by the Council as well as have our own training in house provided by the Safeguarding Team at the Council. Outcome is more awareness of safeguarding issues and how to report alerts
- induction of new staff/volunteers/trustees – now includes presentation on safeguarding that was developed by the Council Safeguarding team
- accessed training on Introduction to Safeguarding/ Child Protection for the Community, Voluntary and Faith groups

As an organisation we have our priorities that are listed in the LSAB Strategic Plan for 2014/2017.

Our priorities for 2014/15 are:-

- organise 10th annual World Elder Abuse Awareness Day events to increase the number of people informed about financial abuse.
- continue training staff and volunteers to spot risk/harm and take appropriate action, so that more clients come forward to report any abuse
- raise awareness about safeguarding issues especially for vulnerable elderly and encourage more people to get help. Outcome same as above
- work with Healthwatch in drawing up a plan to do enter an view sessions and thus raise awareness about safeguarding

3.5 Harrow Police

Outcomes for Prevention and Engagement

Harrow police will continue to support are vulnerable members of the community in particular

- staffing and support to the MASH
- enhanced service to those who are victims of crime including re-assurance visits when they are victims of crime and subsequent re-visits as part of a welfare checking activity
- continue a positive arrest policy for those committing crime in this area
- daily review of crimes with a focus upon Domestic Abuse Racial, Homophobic and Elder crime
- engagement with Partner activities including Secure street days of action

Outcomes for training and Workforce Development

The police will continue train its staff in awareness of vulnerable adults in the community. These include corporate training, delivered in house and also supporting training rolled out by partners to raise awareness of roles, responsibilities and available services provided by partners.

Outcomes for Quality and Performance review

The MPS has rolled out several training packages detailing minimum standards expected when engaging with elderly victims and those suffering MH characteristics. The implementation of this training is routinely tested when dip-sampling police investigation and performance. Financial abuse now falls under the definition of Domestic Abuse and these matters are dealt with by the polices' Community Safety Unit. This allows particular engagement with out financial investigation unit and thus is taken extremely seriously with a wide range of partner agency activity

Outcomes and Policies and Procedure/Governance

Any actions created by the presentation of the LSAB annual report have been dealt with and completed.

3.6 Royal National Orthopaedic Hospital NHS Trust

Outcomes for Prevention and Community Engagement

The RNOH employs Community Liaison Nurses who support the admissions and discharges of patients with spinal cord injuries. There have been safeguarding referrals following their interventions pre - and post-admissions and their input and long-standing knowledge of the patients has proven valuable in addressing the safeguarding needs of very vulnerable patients with highly complex needs.

There is an active Patients advisory liaison group who attend the Trust Board and provide regular representation at the Safeguarding Committees.

Outcomes for Training and Workforce Development

The mandatory adult safeguarding training programme has been reviewed and updated during 2014-15. The training now specifically includes the Mental Capacity Act and Deprivation of Liberty Safeguards. The training for 2014/15 has been face to face, however Level 1 is now available on ELearning.
Safeguarding training now covers FGM, human trafficking, self-neglect and domestic violence to reflect the recent changes made by the Care Act 2014.
Volunteers are now included in the mandatory training programme which covers both adults & children safeguarding and a volunteer coordinator responsible to oversee their activities is in place.

Outcomes for Quality and Performance Review

Following CQC visit in May 2014 and an internal mock CQC inspection in December 2014, it was agreed that safeguarding and MCA/DOLS training should be increased and intensified. This is now a standing item on medical staff annual updates and 'safeguarding days' to cover core skills requirements of clinical staff (safeguarding children, adults and MCA/DOLS) are regularly delivered with good attendance.
An MCA audit has been undertaken and recommendations from this will be presented at the Clinical & Quality Governance Committee for approval. Work will be required to ensure the recommendations are embedded into practice.

The RNOH has also contributed to an IMR for a Domestic Homicide Review. As a result, internal policies and processes are being reviewed to ensure there is a more robust system in place to support people in domestic abusive situations.

Following a recent safeguarding conference, recommendations were made by the Local Authority to address training needs of staff in order to support the additional needs of patients with additional mental health conditions. This is now been taken up by the Lead Educator to ensure appropriate training is sourced. Due to the high numbers of patients with learning disabilities admitted for corrective surgery, specific training for clinical staff is also regularly provided.

Outcomes for Policies and Procedures/Governance

LSAB Annual Report 2013/14 was presented to the RNOH Trust Board in April 2015.

Policies developed following recommendations from CQC and the IMR:

- Domestic Violence
- MCA/DOLS
- Safeguarding Supervision
- Restraint
- Policies for future development:
- Prevent
- Admission of people with learning disabilities

Outcomes for joint work with the LSCB - "think family"

There is regular participation to the Safeguarding Committees by both the adults and the children safeguarding nurses to ensure representation of both services.
Domestic Violence and Safeguarding Supervision Policy have been developed jointly and lessons learnt from cases are shared at both committees.

Priorities for 2015/2016:

- to embed safeguarding into practice
- to develop a robust system to deliver safeguarding supervision throughout the organisation
- implement any recommendations and lessons learnt in relation to safeguarding
- increase trainers and training in PREVENT

3.7 North West London Hospitals NHS Trust

Safeguarding should be viewed as part of everyday business to ensure the patient is at the heart of all we do, whether we be in an acute or out of Hospital setting. In our Partnership agreement for 2015/16 we made a commitment to ensure safeguarding is an integral part of all we do for our patients from admission and at home in the community settings.

We have established a proactive approach to assessing the patient on admission and ensuring we follow and introduce the safeguarding Pan London Policy across the Trust. We have monthly safeguarding meetings where we review and discuss active cases across the Divisions. This is also supported by a quarterly strategic meeting which has external partners. We have introduced policies for Domestic Violence and FGM, together with Dols and implications for the Care Act.

Further working is planned to ensure that we adapt and keep abreast of any changes in the adults safeguarding arena.

Working with our Boroughs in relation to Sexual Exploitation and Slavery.

How do we know they are making a difference?

Ongoing review of the Safeguarding process highlights ways in which we have enhanced the service.

- we have an active up to date Database which records and ensure all aspects of safeguarding are recorded and reported externally
- this ensures that we have an accurate record of events and safeguarding is a part of everyday working for patient safety
- we have external groups for Child exploitation, Domestic Violence and FGM
- the majority of patients had an appropriate risk assessment for falls, Nutrition and Tissue Viability
- for those patients who were at risk of malnutrition and dehydration all had a care plan in place
- 99% of patient who required assistance with feeding were receiving it
- of those patients who were identified as being at risk of developing a pressure sore 99% had an appropriate care plan in place
- 94% of patient report that their privacy and dignity had been maintained
- although the overall incidence of falls for the Trust has not fallen, some wards are reporting a reduction in falls as a result of the Care Round
- reduction of grade 3 or 4 pressure ulcers in 2015/16
- reduction of complaints in some areas
- reviewing everything in regards to patient safety and communicating in an open way with collaborative practices
- we have an agreed safeguarding strategy

Areas we need to improve in 2015/17:

- the sharing and integration with collaborative partners, ensuring local authorities feedback information and share this freely
- PreVent training
- attendance at external meetings
- enlarging the team to ensure staff work across the boundaries in community and acute

3.8 Harrow NHS Clinical Commissioning Group (CCG)

Prevention and Community Engagement

Our Chief Operating officer participated in the health and wellbeing event held on the 16.07.15 at the The Kadwa Patidar Centre, Kenmore Avenue, Harrow, HA3 8LU

Training and Workforce Development

Harrow CCG has employed a part- time Lead Nurse for safeguarding adults since mid-May 2015. The Lead Nurse has completed many of the safeguarding adults training courses accessed via the Harrow LSAB training directory. The Lead Nurse has made arrangements to attend strategy meetings as well as case conferences.

All except 3 members of Harrow CCG staff have received face to face safeguarding adults level 1&2 training delivered by the Lead Nurse. The new categories of abuse as per the Care Act 2014 were embedded into the training with scenarios and very good feedback from staff.

Staff also received training on Prevent, facilitated by the designated nurse for Safeguarding

Quality and Performance Review

Harrow CCG was pleased to be able to take part in the recent Local Adult Safeguarding Board's annual review/business planning event in June 2015. It was a good opportunity for the CCG and local authority as well as service users to review events of the year and make plans of improvement where safeguarding adults was concerned in the coming months.

Policies, Procedures and Governance

The CCG's Safeguarding Adults policy is being updated in view of the recent changes made in the Care Act.2014.

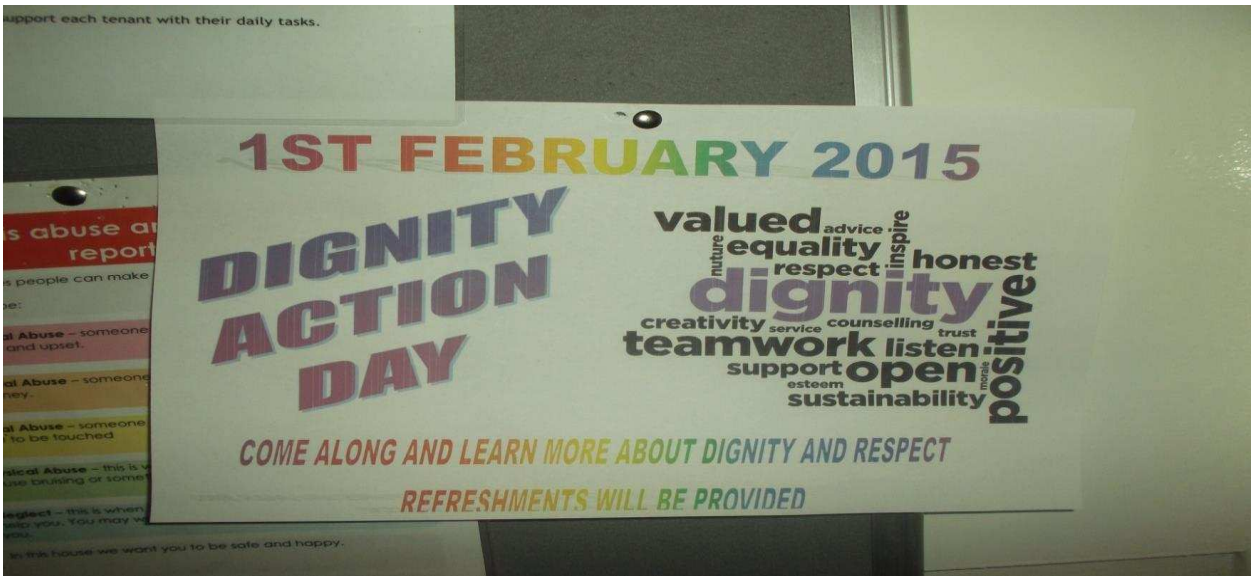
Priorities for 2014/15

- updating of the Safeguarding Adults policy
- ensuring all staff have received safeguarding training and are aware of new government legislation/statutory requirements to aid them in commissioning services

3.9 Harrow Council – Adult Services

Harrow Council's Safeguarding Adults and DoLS Service takes the lead coordinating role for safeguarding vulnerable adults at risk from harm. This role is both in relation to multi-agency strategic development of the work as well as investigations into individual cases of abuse and instances of institutional abuse. The Service also supports the LSAB arrangements; organises a range of public awareness campaigns; oversees the multi-agency training programme and runs briefing sessions.

In 2014/15 as with the previous year, the Safeguarding Adults and DoLS Service had a work programme which supported the overall objectives and priorities in the LSAB Business Plan and progress is monitored at a regular meetings. The work of the Service and any outcomes, including the numbers of referrals handled are covered in the body of this report.



"Harrow is a place where adults at risk from harm are safe and empowered to make their own decisions and where safeguarding is everyone's business" (LSAB Vision)

SECTION 4 – MAKING A DIFFERENCE

(PROGRESS ON OBJECTIVES 2014/2015)

4. Making a Difference – (progress on objectives for 2014/2015)

This section of the report looks at what difference the work of the LSAB made last year by reviewing progress on the priorities agreed for 2014/15, as set out in the annual report for 2013/14.

Theme 1 - Prevention and Community Involvement

The LSAB is confident that prevention of abuse of adults at risk is a high priority in Harrow

The LSAB's prevention strategy 2014 – 2017 ("Promoting Dignity and Prevention of Abuse") was formally agreed at the Board meeting in March 2014. 2014/15 was the first year of implementation which built on the work done from the previous plan. Examples of work in this area include:

Care providers ran events to mark Dignity Awareness Day (February 2015). For example, Blenheim Drug Services ran a "digni-tea" and cakes session for staff and users with discussion about dignity and respect. Jewish Care did the same, followed by a focus group discussion. Simply Care Group have a dignity champion who organised their event, Care Management Group held a dignity action day for people with a learning disability and so did Hestia Floating Support for older people (see pictures above introducing this section).

World Elder Abuse Awareness Day 2014 was marked with a Best Practice Forum on dignity and respect which was attended by 70 staff from a range of local organisations. Some powerful messages were delivered by Amanda Waring (actress and campaigner) both verbally and through her film "What Do You See?" starring Virginia McKenna about dignity in care homes for older people.

The Safeguarding Adults Services attended 4 of the "Safer Streets" events in 2014/15, speaking with members of the public about community safety issues for vulnerable people. Booklets and information were handed out, with the most popular being "The Little Book of Big Scams" produced by the Metropolitan Police and the Home Office.

Outcomes:
There were 61 alerts raised by friends/neighbours and family last year – and it is hoped that sustaining the numbers from the previous year was achieved as a result of the above activities.

Ensure effective communication by the LSAB with its target audiences

A formal Communications Plan for the LSAB was approved by the Board at the March 2015 business meeting. It aims to ensure that its target audiences across the whole community know about abuse and how to report it and that resources are used for publicity and awareness related events in the most time/cost efficient ways.

The LSAB's newsletter which commenced in 2013 continued throughout last year aimed at keeping all relevant individuals and organisations up to date with its work and any key issues that needed to be highlighted. The editions published (September and November 2013; January and March 2014) included topics such as: making safeguarding personal; statistical information; DoLS; loan sharks; Dignity Action Day; Fire Safety; Care Act; LSAB annual report 2013/14 and training information.

The Safeguarding Adults Service attended a wide range of community based events last year to raise awareness. This included several Safer Streets days (see above), an information event for older patients at the Elliott Hall primary care centre; Neighbourhood Champions briefings; and the "keep safe and well" event at Choices for All.

Outcomes:

The referrals from "BME" communities increased last year to 42% (44% of alerts) which is much more in line with the local demographic makeup of the borough.

The very positive arrangements between the Safeguarding Adults Service and the local Fire Service continued last year with 105 referrals for free home fire safety checks (an increase of 45 on the previous year).

Safeguarding Adults priorities are clearly referenced in wider community safety strategies e.g. Domestic Violence

Briefing sessions have been held for 16 more of the borough's Neighbourhood Champions (230 were briefed in 2013/14) who are the "eyes and ears" of the community on their individual street.

As in previous years, the safeguarding adults' contribution to the Council Tax leaflet (which goes to every household in the borough) featured "being a good neighbour", giving the example of distraction burglary and asking residents to be aware of vulnerable people in their street that might be targeted.

Contributions continued from the Safeguarding Adults Service to the Multi-agency Risk Assessment Conference (MARAC – domestic violence focus); Multi-agency Public Protection Arrangements (MAPPA – public safety focus); Prevent (prevention of terrorism focus), and Anti-social Behaviour Group (ASBAG – anti social behaviour focus) - ensuring effective information sharing and communication where vulnerable adults are victims or perpetrators.

Outcomes:

For Operation Conker in September 2014, the Harrow Police were interviewed and answered questions from the public on local community radio about the campaign which was focused on anti-burglary products and making your home looked lived in. The interview included reference to the most vulnerable people in the borough and related safeguarding implications.

There is evidence that the Harrow LSAB's work is influenced by user feedback and priorities

The independent social worker (who interviews randomly selected service users after the safeguarding investigation is concluded) continued last year to ask whether people knew how to report abuse and understood what would happen next. She reported that the majority of users were very happy with the outcome of the investigation. Staff continue to issue the easy to read publication "what happens after I report abuse?" however some people still reported being unclear about the process. New approaches under the "Making Safeguarding Personal" project will embed even further the requirement to start the process being clear about the user's views and to check throughout that they understand what's happening.

Service users attended the LSAB Annual Review Day again last year. They presented a DVD about what was important to them in keeping safe and provided challenge to Board members:

"we are frightened to talk to the Police"

"there is bullying and swearing at the Harrow Bus Station so it's a scary place"

"we are worried about keeping safe on Facebook and about cyber bullying"

"we are worried about nasty messages on mobile phones"

"why haven't more people with mental health difficulties reported abuse?"

Outcomes: as a result the LSAB did the following:

- there was a "Keep Safe in Harrow" session at Choices last December. 70 people came and the Borough Police Commander (Simon Ovens) was there with some of his officers. He gave lots of advice about keeping safe e.g. that the Police have sophisticated technology and excellent links with mobile phone companies, so if users got nasty messages they should keep them and tell the Police. Lots of people talked to the Police at the event and afterwards said that they wouldn't feel so worried about asking a Policeman for help
- more work has been done to set up a Harrow Safe Place scheme. Choices For All students are helping and will be visiting shops, churches and cafes near the Bus Station (as the first priority area) asking them to sign up
- there were more articles in "News and Views" e.g. about fire safety and keeping safe on-line
- CNWL Mental Health NHS Trust carried out a lot of work last year to get information out for people to look at. 3% more people reported abuse last year than the year before

Theme 2 – Quality and Performance Review

The LSAB oversees effective practice and ensures continuous improvement

Performance management reports were presented to the LSAB at all of its meetings in 2014/2015. Following the Peer Review recommendations members were asked to provide input to these reports, however there is still more to do in this regard.

A provider concerns section was added to the performance reports last year so that important information could be shared amongst the LSAB's member organisations.

Peer Review

The Peer Review challenge of safeguarding adults work in Harrow was commissioned by the Council with the full support of the Local Safeguarding Adults Board. This had concluded in 2013/14, so last year focused on implementation of the action plan to address its recommendations. The action plan as at March 31st 2015 is shown at Appendix 4.

Outcomes:

As a result of implementing the Peer Review recommendations examples of outcomes include:

- the Access Harrow "first contact" message for people ringing with concerns was simplified with a specific choice for safeguarding adults
- a "mystery shopping" exercise was commissioned by the LSAB which was carried out by users (supported by Mind in Harrow) in September 2014 with feedback provided to both Access Harrow and CNWL
- more briefing sessions took place at GP surgeries, although this did not result in a further increase in alerts from primary care services

File Audit

Both internal and external (independent) audits of casework continued in the Council's Safeguarding Adults and DoLS Service during 2014/15 with headline massages presented to the LSAB. A total of 105 cases were reviewed with the key focus being on learning from the audit findings and providing feedback to relevant front-line staff and managers.

Outcomes:

Changes were made to the multi-agency training programme and also to the specific sessions for front-line staff. For example, a bespoke course on "unwise decisions" made by vulnerable adults with capacity who choose to put themselves at high risk was commissioned and delivered by a specialist trainer.

Statistical data improves understanding of local patterns enabling improved planning of responses to allegations

The LSAB has received statistical reports at each of its meetings, including the full year position for 2013/2014 at its Annual Review Day. In addition, the new Strategic Plan for 2014 – 2017 included trend analysis looking back over the previous 3 years and all reports included comparison with the national position wherever possible.

Some targeted briefing sessions took place, including for groups not previously visited before including: an Asian day centre for older people; Age UK volunteers; RSPCA staff and volunteers; the Wiseworks Centre for people with mental health difficulties; MIND in Harrow users and volunteers.

Outcomes:

Ongoing analysis by the LSAB of relevant statistical information has enabled adjustments to be made to training events and also to briefing sessions. The most up to date comparisons with the national data shows a positive picture for the work in Harrow with areas identified for future work covered in the action plan at section 5.

Theme 3 –Training and Workforce Development

The LSAB is confident that the local workforce is competent in relation to safeguarding adults' practice – with particular focus on learning from file audits and management reviews e.g. use of the Mental Capacity Act

Multi-agency training remains a high priority for the LSAB. The existing programme is competency based. This ensures that all staff know about the competencies required to meet their safeguarding adults' responsibilities within the workplace.

As a supplement to the formal training programme, the Safeguarding Adults Service also ran briefing sessions across a range of agencies, offering most at the organisation's premises. Full details of the training statistics are at Appendix 2.

Headline messages

- a total of 2143 people received some training in 2014/2015
- 1,115 staff received formal training – this was the same level as in the previous year - the breakdown of formal training was: 224 Council staff (an increase of 47 from 2013/14); 67 NHS staff (an increase of 1 from 2013/14); 9 "other statutory" staff including the Police (a decrease of 9 from 2013/14); 565 private sector staff (an increase of 296 from 2013/14) and 250 voluntary sector staff (an increase of 156 from 2013/14)
- a refresher was organised for elected Councillors and was attended by 35 individuals (an increase of 23 on the previous year)

- 1,028 people attended sessions run by the Safeguarding Adults Service. The breakdown of briefing sessions is shown at Appendix 2 with some new groups e.g. RSPCA staff/volunteers and local Dentists
- a total of 209 staff attended 4 multi-agency best practice forums in 2014/15 on "dignity and respect in care" for WEAAD 2014; "Keep Safe and Well" (joint with the Police and Choices For All); "Recognising the Links" (joint with the LSCB and RSPCA); and "Unwise Decision Making/Mental Capacity"
- there was a 21% reduction in individuals booked on to formal training courses cancelling or failing to attend, a significant decrease following the LSAB decision to charge for non-attendance
- this was the third year for the e-learning course which allows some front line staff to access training that they might otherwise not be able to e.g. GP trainees. A total of 66 staff used the tool last year

Outcomes

Each year the multi-agency training programme and Best Practice Forums are developed from the evaluation and experience of the previous year's sessions. They also cover the areas that successive independent audits of safeguarding cases and the Peer Review suggested for further improvements in staff knowledge and/or confidence. An ongoing high priority was given to mental capacity training, and new topics included "train the trainer" so that organisations can run more in-house sessions, and "what I need to know as the lead for my organisation?" – both being well received by attendees.

....

DOLS arrangements (including for health funded services and facilities) are effective

The full set of Deprivation of Liberty Safeguards (DoLS) statistics are shown at Appendix 1. Analysis of the statistics is at section 2.2 of this report.

The statutory timescales were met in all the cases assessed last year in Harrow which in comparison to many other Councils across the country where there are significant waiting lists is excellent.

Outcomes:

The LSAB can be reassured that for the 304 cases where a DoLS was authorised, some of the most vulnerable people have been protected. It is also positive that more cases were referred from hospitals (15) suggesting that staff in those settings are becoming clearer about their responsibilities as managing authorities.

Theme 4 - Policies and Procedures/Governance

Ensure production of the LSAB Annual Report

The LSAB Annual Report 2013/2014 was agreed formally by the Board at its annual review day in June 2014. This report for 2014/2015 will be discussed at the same event in June 2015. Subsequently the report will be presented to the Council's Scrutiny Committee, the Health and Wellbeing Board and partner agencies' Executive meetings or equivalent.

Outcomes:
As in previous years, following the decision to sign off the annual report by the LSAB last June a "key messages for staff" version of the report was produced for the second time and an easy to read version was put on the Council's website – aiming to ensure that the Board's work is as accessible as possible to both staff and the public.

Ensure that the LSAB Annual Report is presented to all relevant accountable bodies

Following its formal agreement at the LSAB annual review day in 28th June 2014, the report was presented to the Council's Scrutiny Committee in July, the Health and Wellbeing Board in September and subsequently to all partner agencies' Executive meetings or equivalent.

The general public is aware of safeguarding issues and the work of the LSAB

As stated earlier in this report, the Safeguarding Adults Service attended a wide range of community based events last year to raise awareness. This included several Safer Streets days (see above), an information event for older patients at Elliott Hall primary care centre; Neighbourhood Champions briefings; and the "keep safe and well" event at Choices for All. The information in the Council tax leaflet (pushed through every letter box) and the community radio coverage were further examples of the service trying to reach out to the general public. Other broader campaigns included articles in the Fire Safety magazine "fire is not the only danger you face" and an article in "Homing In" the Council's Housing Department newsletter for all tenants.

The safeguarding adults' website was kept up to date and has a section for easy to read information.

The LSAB (jointly with the LSCB) takes a "family first" approach to its work

The joint protocols developed in 2013/14 by the LSAB/LSCB sub-group and formally launched by the chairs of the 2 Boards in October 2013 were refreshed last year.

Work between the two Boards continued with (for example) a joint best practice forum on "recognising the links" at which the RSPCA presented information about the growing recognition of risks for children or vulnerable adults in homes where animals are abused and vice versa. Wherever appropriate, meetings where there are common issues are held jointly e.g. the bi-annual meeting with the London Ambulance Service.

Outcomes:

The independent/external file auditor reported again last year that workers in the safeguarding adults team were demonstrating confidence in a "family first" approach, stating that all the relevant (audited) cases had been appropriately referred to Children's Services. In the most recent audit there were also examples of good practice highlighted where joint work on complex cases had produced a more positive outcome for the user.

The LSAB has strategic oversight of local safeguarding adults work

Year one actions from the LSAB Strategic Plan 2014 – 2017 were implemented with an exception report at each Board meeting. This section of the annual report covers the work carried out and some of the outcomes achieved as a result.

Theme 5 – Partnership with the Local Safeguarding Children's Board (LSCB)

Common joint safeguarding needs are identified in terms of Domestic Violence and actions prepared to address gaps, including mapping key pathways to MARAC

Independent file audit last year also reviewed cases where domestic violence was a factor. The LSAB was reassured by the finding that referrals were being routinely made to MARAC and it is becoming much more common for a worker or manager from the Safeguarding Adults/DOLS Service to attend the meetings for specific cases.

Some audited cases also recognised work done with both the Looked After Children's and Children with Disability Teams.

Outcomes:

Better outcomes for young adults in specific cases where joint work was effective.

The LSAB (jointly with the LSCB) takes a "family first" approach to its work

See above. In addition, a practitioner representative from the Council's Safeguarding Adults/DoLS Service and relevant NHS staff provide information for the daily MASH (Multi-agency Safeguarding Hub) meeting where threshold decisions about referred children are discussed. This ensures appropriate information sharing and therefore decisions are taken in the most informed way possible.

"Harrow is a place where adults at risk from harm are safe and empowered to make their own decisions and where safeguarding is everyone's business" (LSAB Vision)

SECTION 5 – OBJECTIVES FOR 2015/2016
(YEAR 2 OF THE STRATEGIC PLAN 2014 – 2017)

Theme 1 – Prevention and Community Engagement

Overall objective

All the agencies in Harrow represented at the LSAB have agreed to take a "zero tolerance" approach to the abuse of adults at risk from harm. The vision for the Board adopted in 2011 states that "Harrow is a place where adults at risk from harm are safe and empowered to make their own decisions and where safeguarding is everyone's business". As such the LSAB has agreed that the prevention of abuse (in both domestic and institutional settings), publicity campaigns and information which reaches all sections of the community should be a high priority.

NB. There are a range of actions for all partner agencies that will be taken forward in 2014/2015 not reflected below as the LSAB objectives are at the strategic level. Some are contained within the documents that supplement the Strategic Plan 2014 – 2017 and others are single agency.

Objectives and Targets	How it will be achieved and measured (outcomes)	Timescale
The LSAB is confident that prevention of abuse of adults at risk is a high priority in Harrow Source: PR; WV; CA and ADASS	Implement the Prevention Strategy 2014 – 2017 Updates on progress presented at Board business meetings (user outcomes)	March/April 2016 March/April 2017 Quarterly at Business Meetings
Ensure effective communication by the LSAB with its target audiences Source: ADASS and CA	Implement the LSAB Communications Policy as agreed at the March 2015 business meeting (service delivery and effective practice)/(user outcomes)	End March 2016

Safeguarding Adults priorities are clearly referenced in wider community safety strategies e.g. Domestic Violence Source: HPS and CA	Specific projects to tackle wider community safety issues as highlighted by users (e.g. hate crime; safe travel on public transport; distraction burglary/doorstop crime; safe place scheme and home fire safety) are taken forward over the 3 years of the LSAB Strategic Plan – and users report feeling safer in annual surveys and in focus group discussions (user outcomes); (leadership); (strategy)	End March 2016
There is evidence that the Harrow LSAB's work is influenced by user feedback and priorities Source: CA; MSP	Update the 2012 LSAB User Engagement Strategy in context of the Care Act 2014 and Making Safeguarding Personal Demonstrable changes in policy and practice are evident following annual evaluation of user feedback and presentation at the LSAB Review Day; Local Account Group and similar (user outcomes); (people's experiences of safeguarding)	End December 2015

Theme 2 – Training and Workforce Development

Overall objective

In adopting the ADASS standards for Safeguarding Adults at risk, the LSAB has signed up to a multi-agency workforce development/training strategy. In addition, the main messages drawn from the Bournemouth University/Learn To Care research (May 2010) "Towards a National Competence Framework for Safeguarding Adults" suggests that there needs to be better coordination, quality and breadth of multi-agency staff training.

NB. There are a range of actions for all partner agencies that will be taken forward in 2014/2015 not reflected below as the LSAB objectives are at the strategic level. Some are contained within the documents that supplement the Strategic Plan 2014 – 2017 and others are single agency.

Objectives and Targets	How it will be achieved and measured (outcomes)	Timescale
The LSAB is confident that the local workforce is competent in relation to safeguarding adults' practice – with particular focus on learning from file audits and management reviews e.g. use of the Mental Capacity Act Source: BU; file audit; HPR and CA	Formally evaluate the multi-agency and single agency training programmes with a focus on outcomes for participants in practice Update the training programme to cover requirements of MSP and the Care Act e.g. to include self-neglect; modern slavery (service delivery and effective practice)	Report to the December LSAB meeting End July 2015
DOLS arrangements (including for health funded services and facilities) are effective Source: HWB and WV	LSAB receives DoLS performance information at each Business Meeting (people's experiences of safeguarding)	Quarterly End March 2016

Theme 3 – Quality and Performance Review

Overall objective

The LSAB has agreed to oversee robust performance management frameworks for monitoring the quality and effectiveness of safeguarding work across all sectors. The existing QA framework is shown at Appendix 2 and has user/carer challenge at its centre.

NB. There are a range of actions for all partner agencies that will be taken forward in 2014/2015 not reflected below as the LSAB objectives are at the strategic level. Some are contained within the documents that supplement the Strategic Plan 2014 – 2017 and others are single agency.

Objectives and Targets	How it will be achieved and measured (outcomes)	Timescale
The LSAB oversees effective practice and ensures continuous improvement Source: HPR; NHS; ADASS and CA	The recommendations from the formal Peer Review of safeguarding adults work in Harrow are completed Update the LSAB complaints policy to ensure Care Act and MSP compliance (jointly with the LSCB) (performance and resource management)	End December 2015 End December 2015
Statistical data improves understanding of local patterns enabling improved planning of responses to allegations Source: HPR; SAR; CA and AR	Ensure presentation of statistics at each LSAB Business Meeting and at the Annual Review Day, including comparisons with the national SAR data – with resulting actions agreed including: ongoing priority for police action/prosecution in relevant cases; more use of the Court of Protection; mental health referral numbers (performance and resource management)	Quarterly

The LSAB is confident that safeguarding adults work is person centred Source: HPR; MSP	The LSAB User Engagement Strategy is updated in light of the Care Act and Making Safeguarding Personal LSAB receives reports on action plan implementation for the Harrow Safeguarding Adults Service involvement in the Making Safeguarding Personal (national) project (service delivery and effective practice)	End December 2015 End March 2016

Theme 4 - Policies and Procedures/Governance

Overall objective

In adopting the ADASS standards for Safeguarding Adults at risk, the LSAB has signed up to a multi agency partnership, oversight by each organisation's executive body to the work and the pan London Policy & Procedures that describe the framework for responding to alerts/referrals.

NB. There are a range of actions for all partner agencies that will be taken forward in 2014/2015 not reflected below as the LSAB objectives are at the strategic level. Some are contained within the documents that supplement the Strategic Plan 2014 – 2017 and others are single agency.

Objectives and Targets	How it will be achieved and measured (outcomes)	Timescale for achievement
Ensure production of the LSAB Annual Report Source: HPR and CA	LSAB receive Annual Report within 3 months of the end of the financial year – with a focus on outcomes wherever possible (Local Safeguarding Adults Board)	End June 2015
Ensure that the LSAB Annual Report is presented to all relevant accountable bodies Source: PR; AR; CA	Presentation made to Scrutiny Committee to include progress against the previous year's action plan and objectives for the coming year	First available Scrutiny meeting after the Annual Report is discussed and agreed at the LSAB (and no later than the end of September 2015)

	All partner agencies present the Annual Report to their Board (or equivalent) within 3 months of the agreement by the LSAB Presentation made to Health and Wellbeing Board with particular reference to progress on agreed joint priorities and recommendations for the coming year (leadership); (Local Safeguarding Adults Board); (Strategy)	First available Board meeting after the Annual Report is discussed and agreed at the LSAB (and no later than the end of September 2015) First available Health and Wellbeing Board meeting after the Annual Report is discussed and agreed at the LSAB (and no later than the end of September 2015)
The general public is aware of safeguarding issues and the work of the LSAB Source: ADASS and PR	Implement the LSAB Communications Policy as agreed by the Board at its March 2015 business meeting The LSAB Annual Report is published in an easy to read format and posted on all partner websites (service delivery and effective practice)	End March 2016 End September 2015
The statutory LSAB is effective; Care Act compliant and has strategic oversight of local safeguarding adults work Source: ADASS; CA and HPR	The LSAB Strategic Plan is monitored at Board meetings and updated at the Annual Review/Business Planning Day The LSAB agrees an effective approach to fulfil its responsibilities for overseeing work on self-neglect	Quarterly and end of June 2016 End December 2015

	Board governance and arrangements are reviewed and post April 2015 meet Care Act 2014 requirements – specifically: • review the partnership agreement • review the information sharing agreement • replace the Serious Case Review (SCR) policy with a Safeguarding Adults Review (SAR) policy • confirm with all LSAB members which posts in their organisation have the Designated Adult Safeguarding Manager (DASM) role attached • confirm the role of Harrow Healthwatch with the LSAB (leadership)	End March 2016
Ensure local arrangements are Pan London Policy/Procedures compliant and cover the new safeguarding areas e.g. human trafficking Source: CA	The LSAB formally adopts the new pan London procedures when available	As determined by relevant guidance when the new procedures are issued

Theme 5 – Partnership with the Local Safeguarding Children's Board (LSCB)

The LSAB and LSCB have agreed to work in collaboration to ensure sharing of information, learning and ideas such that effective and safe services are offered with a "family first" approach. This ensures that staff working in Children's Services recognise any vulnerable adults in the family and staff working with adults recognise any risks to children. The key areas that will be taken forward under this theme are:

NB. There are a range of actions for all partner agencies that will be taken forward in 2014/2015 not reflected below as the LSAB objectives are at the strategic level. Some are contained within the documents that supplement the Strategic Plan 2014 – 2017 and others are single agency.

Objectives and Targets	How it will be achieved and measured (outcomes)	Timescale for achievement
Common joint safeguarding needs are identified in terms of Domestic Violence and actions prepared to address gaps, including mapping key pathways to MARAC. Source: PR and ADASS	Consider all possible areas for joint approaches e.g. in relation to safeguarding training, work with schools and sexual exploitation (working together)	End March 2016
The LSAB (jointly with the LSCB) takes a "family first" approach to its work Source: WV and NHS	Relevant range of key protocols in place e.g. for the relationship between the LSAB and LSCB (working together)	End September 2015

Source Documents:

AR – Local Safeguarding Adults Board Annual Reports

HPR – Harrow formal Peer Review recommendations

PR – Peer Review (incorporating Association of Directors of Adult Social Services – National Framework for Good Practice Standards; Care Quality Commission (CQC) reports and the reviews of “No Secrets” and “Putting People First”)

NHS – National Health Service audit tool (local priorities)

BU - Bournemouth University/Learn To Care research “Towards A National Competence Framework For Safeguarding Adults” (May 2010) and Harrow (Safeguarding Adults Board) Training Strategy

FA - File Audit learning/recommendations

WV – Winterbourne View or Francis report findings and Government response

HWB – Health and Wellbeing Board priority

SAR – national statistics (Harrow data)

UES – Harrow (Safeguarding Adults Board) User Engagement Strategy

HPS - Harrow (Safeguarding Adults Board) Prevention Strategy 2014 - 2017

ADASS – Advice and guidance to Directors of Adult Social Services

CA – Care Act 2014

MSP – Making Safeguarding Personal

"Harrow is a place where adults at risk from harm are safe and empowered to make their own decisions and where safeguarding is everyone's business" (LSAB Vision)

SECTION 6 – APPENDICES

Appendix 1	Safeguarding Adults and Deprivation of Liberty Safeguards (DoLS) statistics
Appendix 2	Training statistics
Appendix 3	LSAB Quality Assurance Framework
Appendix 4	Peer Review action plan as at 31st March 2015
Appendix 5	LSAB membership as at March 31st 2015
Appendix 6	LSAB meeting attendance record 2014 - 2015

Safeguarding Adults Alert & Referral Data - 1st April 2014 - 31st March 2015

Summary Statistics

No. of Alerts: -	**1227**	**%**
Taken forward as Refs: -	629	51%
Dealt with at Alert Stage: -	598	49%
No. of Repeat Refs: -	112	18%
No. of Completed Refs: -	551	88%
Alerts Female	794	65%
Alerts Male	431	35%
Not Stated / Recorded	2	0%
	1227	**100%**
Referrals Female	399	63%
Referrals Male	230	37%
Not Stated / Recorded	0	0%
	629	**100%**
From different Ethnic Backgrounds (non white UK): -	**549**	**46%**
Female	370	66%
Male	177	31%
(ethnicity) Not Stated / Recorded	17	3%
	564	**100%**
(ethnicity) Not Stated / Recorded or	**W/UK**	**BME**
White UK	663	564
White UK	54%	46%

Alerts

From different Ethnic Backgrounds (non white UK): -	**271**	**44%**
Female	182	67%
Male	89	33%
(ethnicity) Not Stated / Recorded	8	1%
	279	**101%**
(ethnicity) Not Stated / Recorded or	**W/UK**	**BME**
White UK	350	279
White UK	56%	44%

Referrals

Where Abuse / Harm took Place: -		
Own Home	382	61%
Care Home - Permanent	71	11%
Care Home with Nursing - Permanent	52	8%
Care Home - Temporary	4	1%
Care Home with Nursing - Temporary	7	1%
Alleged Perpetrators Home	5	1%
Mental Health Inpatient Setting	12	2%
Acute Hospital	13	2%
Community Hospital	7	1%
Other Health Setting	1	0%
Supported Accommodation	30	5%
Day Centre/Service	6	1%
Public Place	12	2%
Education/Training/Workplace Establishment	4	1%
Other	16	3%
Not Known / Not Recorded	7	1%
	629	**100%**

Many cases involve multiple locations of abuse and this is highlighted in these figures

Service User Group: -		
Older People	363	58%
Learning Disability	88	14%
Physical Disability Support	332	53%
Mental Health	103	16%
Support with Memory and Cognotion	54	9%
Sensory Support	19	3%
Substance Misuse	0	0%
Other Adult at Risk / Social Support	60	10%
Not Stated / Recorded	50	8%
Total No. of Service Users	**629**	**170%**
No. of Multiple Service User Groups	**440**	**70%**

Some Service Users have multiple conditions e.g. older person with a physical disability and mental health issue and this is highlighted in these figures

Type of Abuse / Harm: -		
Physical	223	28%
Sexual	42	5%
Emotional/Psychological	177	22%
Financial	159	20%
Neglect	183	23%
Discriminatory	6	1%
Institutional	4	1%
Not Stated / Recorded	0	0%
Multiple Abuses	165	21%
	794	**121%**

Many cases involve multiple abuses and this is highlighted in these figures

Person Alleged to have caused Abuse / Harm:-			
	Health Care Worker	34	5%
	Neighbour or Friend	55	9%
	Main Family Carer / Other Family Member	186	30%
	Other Professional	15	2%
	Other Vulnerable Adult	28	4%
	Partner	50	8%
	Social Care Staff	128	20%
	Stranger	49	8%
	Volunteer or Befriender	0	0%
	Other	51	8%
	Not Known/Stated/Recorded	33	5%
		629	**100%**

	Source of Referral		
Social Care Staff	Domiciliary Staff	27	4%
	Residential Care Staff	53	8%
	Day Care Staff	28	4%
	Social Worker/Care Manager	126	20%
	Self -Directed Care Staff	5	1%
	Other Social Care Worker	37	6%
Health Staff	Primary/Community Health Staff	76	12%
	Secondary Health Staff	99	16%
	Mental Health Staff	4	1%
	Other Health Care Worker	0	0%
Other Sources of Referral	Self-Referral	17	3%
	Family member	54	9%
	Friend/neighbour	9	1%
	Other Service User	2	0%
	Care Quality Commission	4	1%
	Education/Training/Workplace Establishment	2	0%
	Housing	14	2%
	Police	29	5%
	Other (anon, probation, contracts, MAPPA, MARAC, etc	43	7%
	Not Recorded	0	0%
		629	**100%**

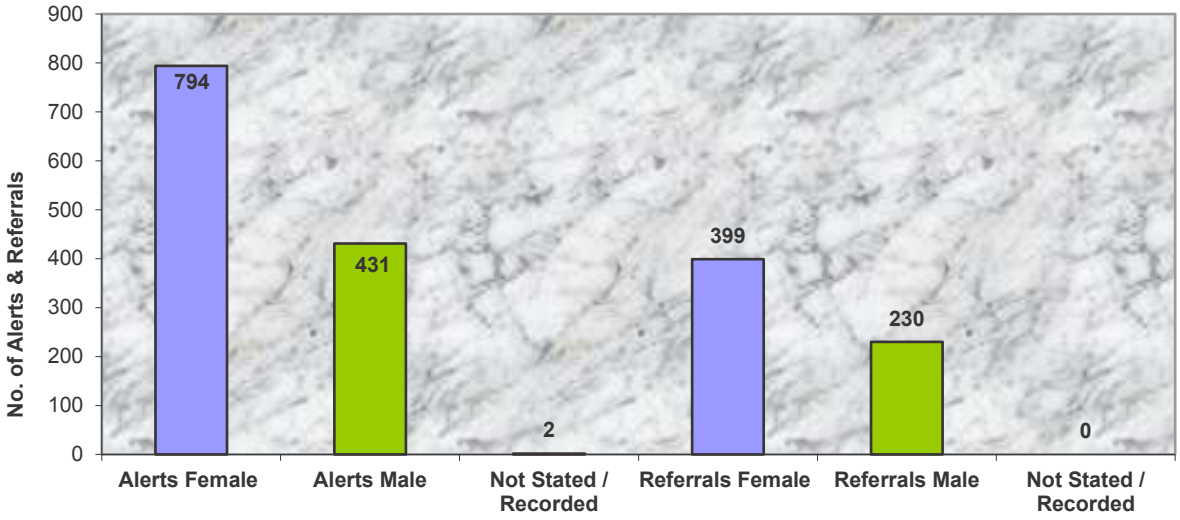
Outcomes for Adult at Risk (completed cases) :-			
	Increased Monitoring	94	12%
	Removed from property or service	35	5%
	Community Care Assessment & Services	89	12%
	Civil Action	2	0%
	Apllication to Court of Protection	4	1%
	Application to change appointee-ship	0	0%
	Referral to advocacy scheme	12	2%
	Referral to Counselling/Training	16	2%
	Moved to increase/Different Care	36	5%
	Management of access to finances	16	2%
	Guardianship/Use of Mental Health Act	1	0%
	Review of Self Directed Support (IB)	13	2%
	Management of access to Perpetrator	43	6%
	Referral to MARAC	13	2%
	Other	211	28%
	No Further Action	173	23%
	Not Recorded	0	0%
		758	**100%**

Many cases allow for multiple outcomes and this is highlighted in these figures

Outcomes for Person Alleged to have caused the Abuse / Harm (completed cases) :-			
	Criminal Prosecution/Formal Caution	17	2%
	Police Action	72	10%
	Community Care Assessment	26	4%
	Removal from Property or Service	44	6%
	Management of Access to Adult at Risk	34	5%
	Referred to ISA / DBS	8	1%
	Referral to Registration Body	12	2%
	Disciplinary Action	23	3%
	Action By Care Quality Commission	12	2%
	Continued Monitoring	43	6%
	Counselling/Training/Treatment	21	3%
	Referral to Court Mandated Treatment	1	0%
	Referral to MAPPA	1	0%
	Action under Mental Health Act	7	1%
	Action by Contract Compliance	28	4%
	Exoneration	28	4%
	No Further Action	266	37%
	Not Known	75	10%
	Not Recorded	0	0%
		718	**100%**

Many cases allow for multiple outcomes and this is highlighted in these figures

Safeguarding Adults Alerts & Referrals 1st April 2014 - 31st March 2015
Male / Female Ratio

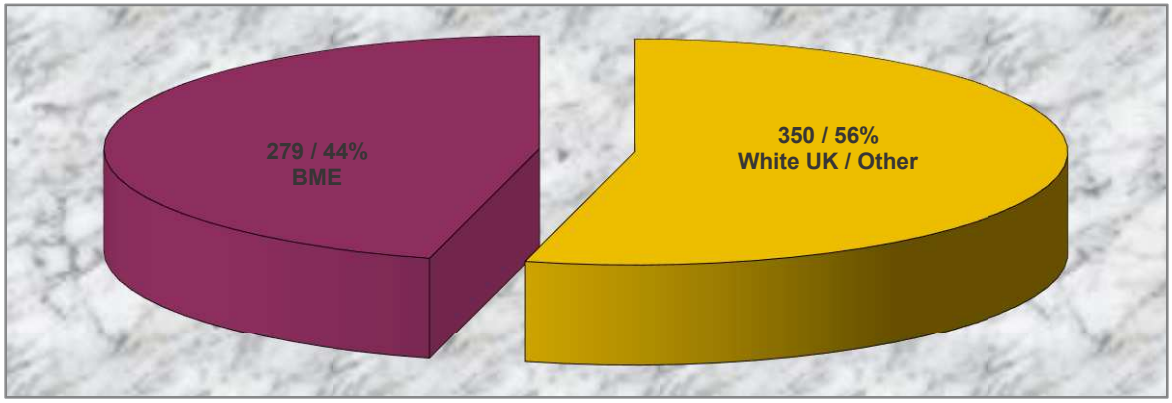


Total No. of Alerts - 1227
Proceeding to Referrals - 629

Safeguarding Adults Referrals 1st April 2014 - 31st March 2015
Male / Female Ratio
(from different ethnic backgrounds)

Total No. of Referrals - 629 (8 did not state / record ethnicity but did record gender)
% of overall referrals - 44%

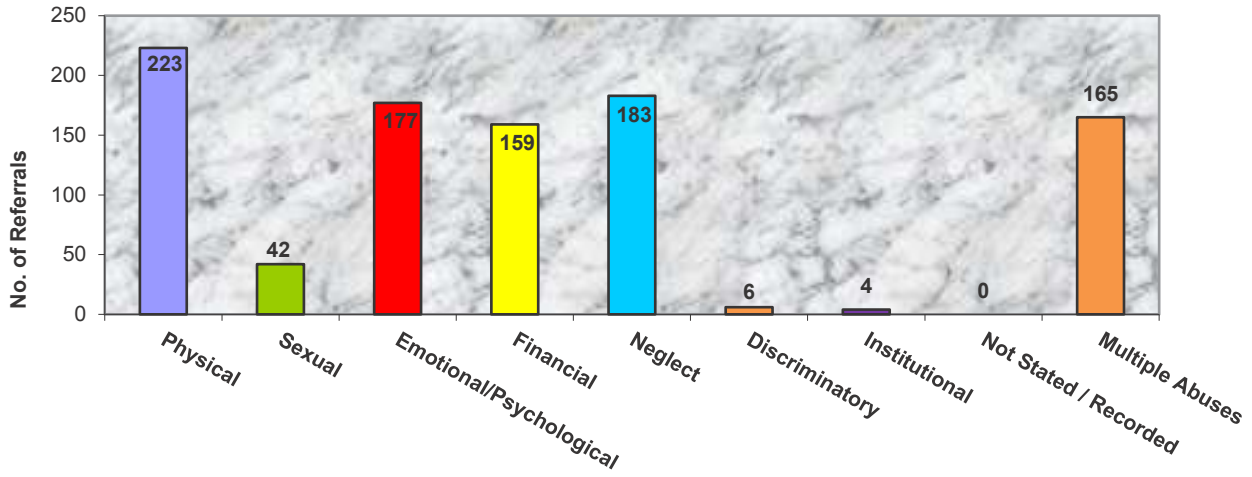
Safeguarding Adults Referrrals 1st April 2014 - 31st March 2015
W/UK / BME Ratio



% Adult BAME Community in Harrow
(from 2011 Census) - 42%

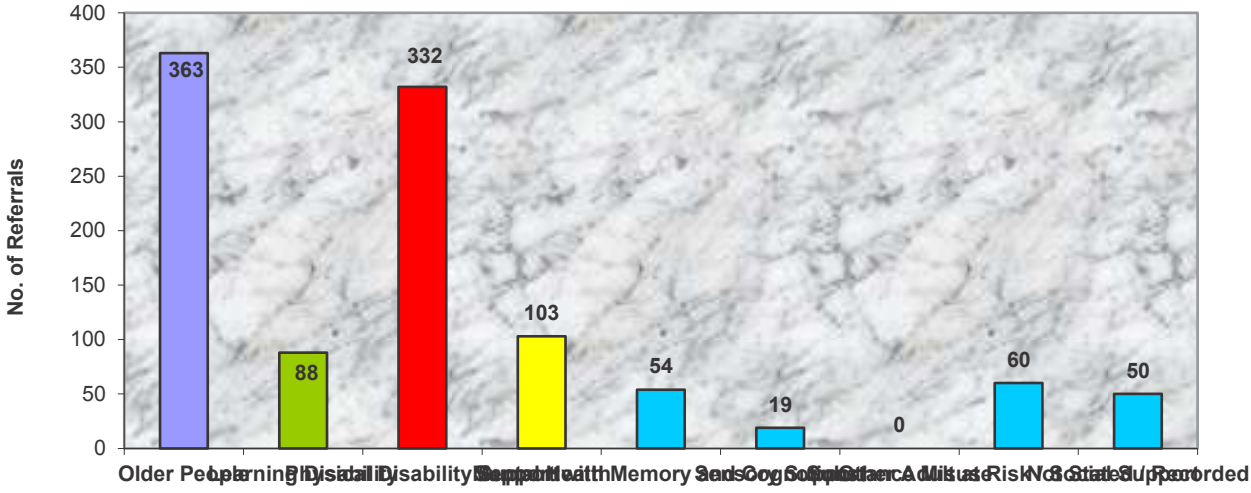
% BME Safeguarding Alerts - 46%
% BME Safeguarding Referrals - 44%

Safeguarding Adults Referrals 1st April 2014 - 31st March 2015
Referrals by Type of Alleged Abuse



Total No. of Referrals - 629

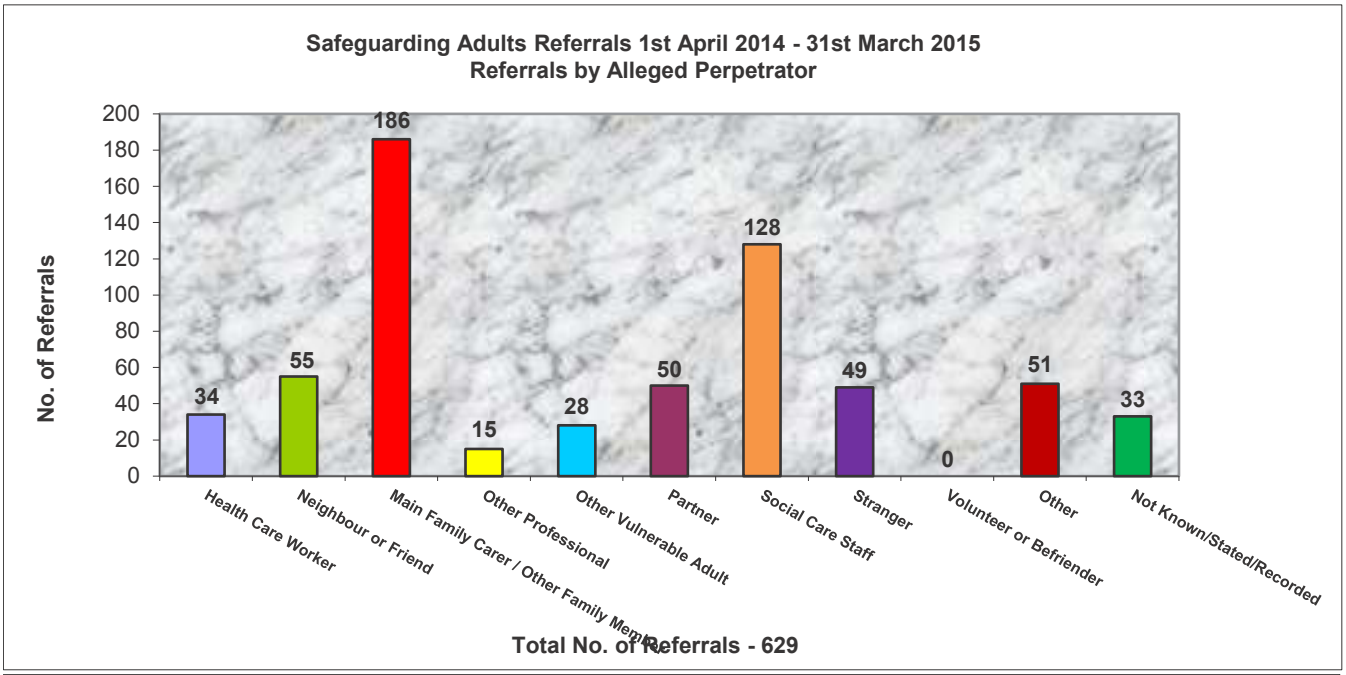
Safeguarding Adults Referrals 1st April 2014 - 31st March 2015
Referrals by Client Group

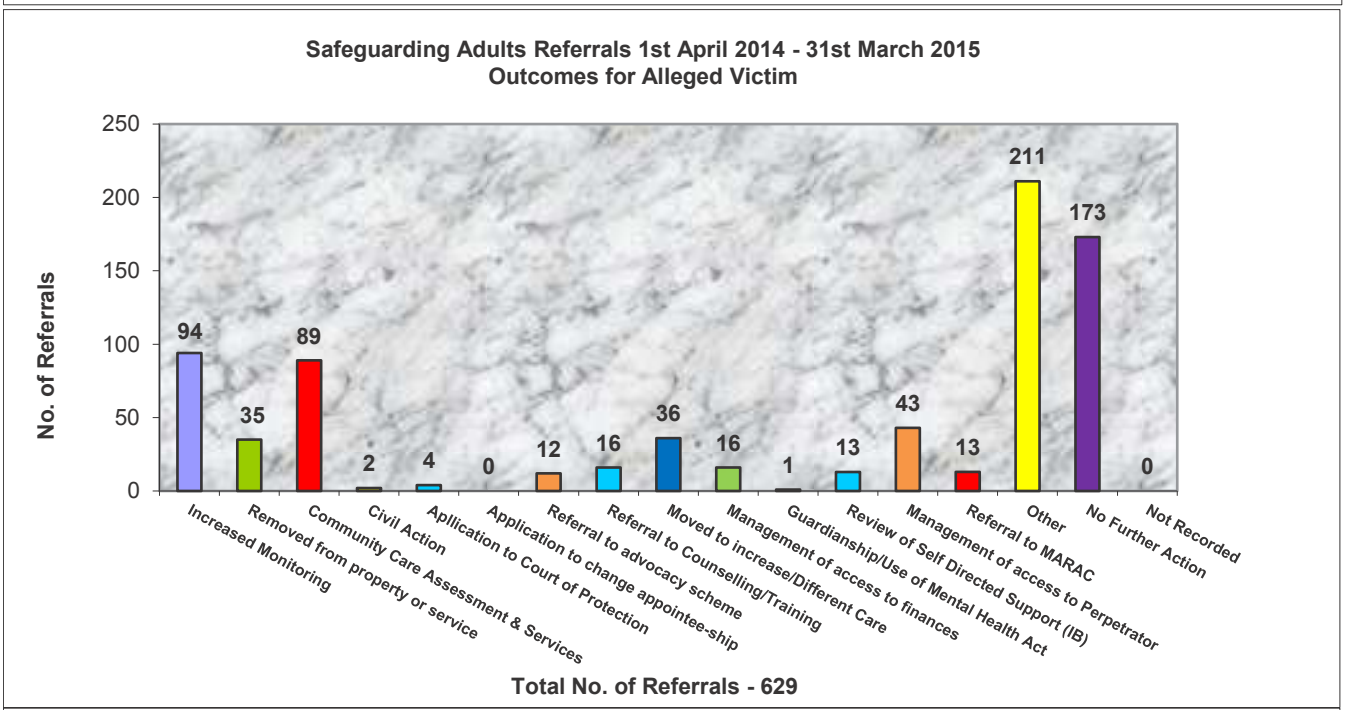


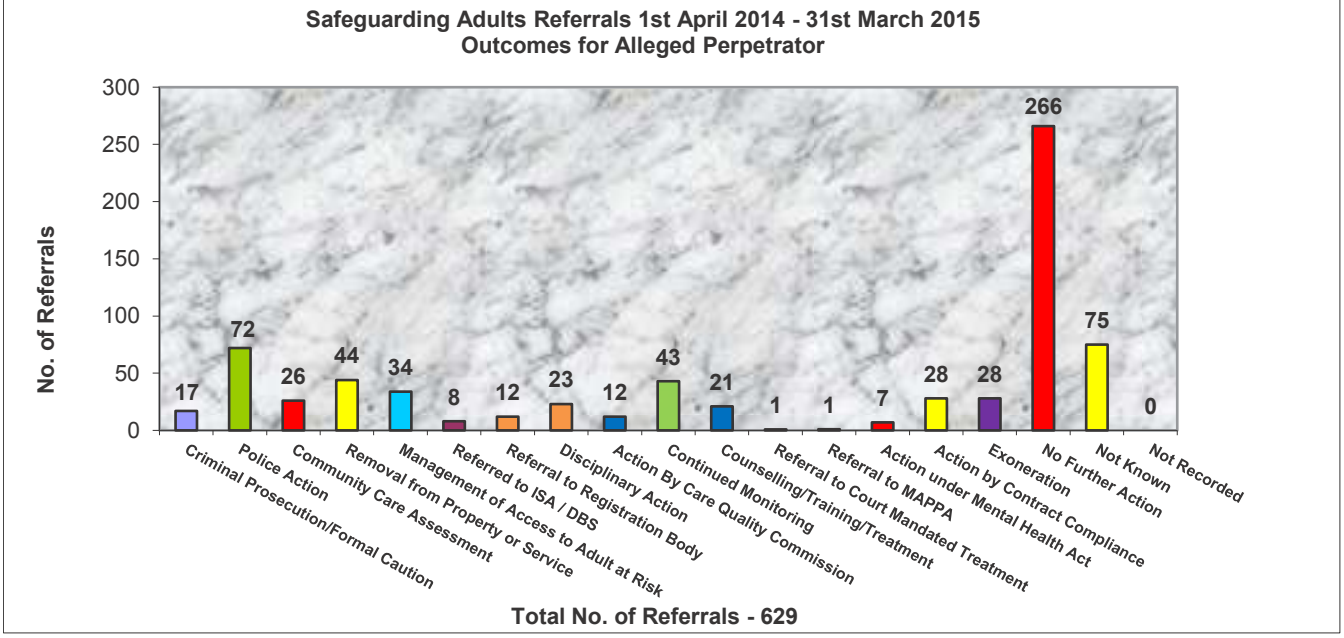
Total No. of Referrals - 629

Safeguarding Adults Referrals 1st April 2014 - 31st March 2015
Referrals by Location of Abuse

Total No. of Referrals - 629


Safeguarding Adults Referrals 1st April 2014 - 31st March 2015
Referrals by Alleged Perpetrator
No. of Referrals
200
180
160
140
120
100
80
60
40
20
0
34
55
186
15
28
50
128
49
0
51
33
Health Care Worker
Neighbour or Friend
Main Family Carer / Other Family Member
Other Professional
Other Vulnerable Adult
Partner
Social Care Staff
Stranger
Volunteer or Befriender
Other
Not Known/Stated/Recorded
Total No. of Referrals - 629


Safeguarding Adults Referrals 1st April 2014 - 31st March 2015
Outcomes for Alleged Victim
No. of Referrals
250
200
150
100
50
0
94
35
89
2
4
0
12
16
36
16
1
13
43
13
211
173
0
Increased Monitoring
Removed from property or service
Community Care Assessment & Services
Civil Action
Apllication to Court of Protection
Application to change appointee-ship
Referral to advocacy scheme
Referral to Counselling/Training
Moved to increase/Different Care
Management of access to finances
Guardianship/Use of Mental Health Act
Review of Self Directed Support (IB)
Management of access to Perpetrator
Referral to MARAC
Other
No Further Action
Not Recorded
Total No. of Referrals - 629


Safeguarding Adults Referrals 1st April 2014 - 31st March 2015
Outcomes for Alleged Perpetrator
No. of Referrals
300
250
200
150
100
50
0
17
72
26
44
34
8
12
23
12
43
21
1
1
7
28
28
266
75
0
Criminal Prosecution/Formal Caution
Police Action
Community Care Assessment
Removal from Property or Service
Management of Access to Adult at Risk
Referred to ISA / DBS
Referral to Registration Body
Disciplinary Action
Action By Care Quality Commission
Continued Monitoring
Counselling/Training/Treatment
Referral to Court Mandated Treatment
Referral to MAPPA
Action under Mental Health Act
Action by Contract Compliance
Exoneration
No Further Action
Not Known
Not Recorded
Total No. of Referrals - 629

Summary for 01/04/2014 00:00:00 to 31/03/2015 23:59:00

Number of concerns	1227	
Number of concerns (LBH)	1094	
Number of concerns (external)	133	
Number of enquiries	629	51.3%
Number of enquiries (LBH)	552	
Number of enquiries (external)	77	
Dealt with at concerns stage	598	48.7%
Number of repeat enquiries	112	9.1%
Number of completed enquiries	551	44.9%
Number of completed (LBH)	487	
Number of completed (external)	64	
Female concerns	794	64.7%
Male concerns	431	35.1%
Unknown gender concerns	2	0.2%

Enquiry gender	F	399	63.4%
Enquiry gender	M	230	36.6%

Concerns by ethnicity

	F	M	U	Total	%
BME	370	177	2	549	44.7%
Not stated	10	5		15	1.2%
White UK	414	249		663	54.0%
Totals	794	431	2	1227	

Enquiries by ethnicity

	F	M	Total	%
BME	182	89	271	43.1%
Not stated	5	3	8	1.3%
White UK	212	138	350	55.6%
Totals	399	230	629	

Concerns by location

	Count of ale	%
Own home	719	58.6%
Residential Care Home - Permanent	128	10.4%
Nursing Care Home - Permanent	93	7.6%
Supported Accommodation	49	4.0%
Not known	33	2.7%
Other	31	2.5%
Public Place	25	2.0%
Acute Hospital	24	2.0%
Mental Health Inpatient Setting	22	1.8%
Community Hospital	18	1.5%
Nursing Care Home - Temporary	16	1.3%
Day Centre/Service	10	0.8%
Home of alleged	9	0.7%
Residential Care Home - Temporary	9	0.7%
Education/Training/Workplace Establishment	7	0.6%
Other Health Setting (including Hospice)	6	0.5%
Own home; Public Place	5	0.4%
Own home; Other	3	0.2%
Own home; Supported Accommodation	3	0.2%
Own home; Community Hospital	2	0.2%
Acute Hospital; Community Hospital	1	0.1%
Community Hospital; Other Health Setting (including H	1	0.1%
Home of alleged; Other	1	0.1%
Nursing Care Home - Permanent; Community Hospital	1	0.1%
Nursing Care Home - Permanent; Supported Accommo	1	0.1%
Other; Not known	1	0.1%
Own home; Acute Hospital	1	0.1%
Own home; Home of alleged	1	0.1%
Own home; Mental Health Inpatient Setting	1	0.1%
Own home; Nursing Care Home - Permanent	1	0.1%
Own home; Public Place; Home of alleged	1	0.1%
Own home; Public Place; Other	1	0.1%
Residential Care Home - Permanent; Acute Hospital	1	0.1%
Residential Care Home - Permanent; Residential Care I	1	0.1%
Supported Accommodation; Home of alleged	1	0.1%
Total	1227	

Enquiries by location

	Count of referrals	%
Own home	372	59.1%
Residential Care Home - Permanent	70	11.1%
Nursing Care Home - Permanent	51	8.1%
Supported Accommodation	29	4.6%
Other	16	2.5%
Acute Hospital	13	2.1%
Mental Health Inpatient Setting	12	1.9%
Public Place	12	1.9%
Not known	7	1.1%
Nursing Care Home - Temporary	7	1.1%
Community Hospital	6	1.0%
Day Centre/Service	6	1.0%
Home of alleged	5	0.8%
Education/Training/Workplace Establishment	4	0.6%
Residential Care Home - Temporary	4	0.6%
Own home; Other	3	0.5%
Community Hospital; Other Health Setting (including Hospice)	1	0.2%
Nursing Care Home - Permanent; Community Hospital; Other	1	0.2%
Other Health Setting (including Hospice)	1	0.2%
Own home; Community Hospital	1	0.2%
Own home; Home of alleged	1	0.2%
Own home; Nursing Care Home - Permanent	1	0.2%
Own home; Public Place	1	0.2%
Own home; Public Place; Home of alleged	1	0.2%
Own home; Public Place; Other	1	0.2%
Own home; Supported Accommodation	1	0.2%
Residential Care Home - Permanent; Acute Hospital	1	0.2%
Supported Accommodation; Home of alleged	1	0.2%
Total	629	

Concerns by primary support rea

	Count of ale	%
Physical Support	589	48.0%
Learning Disability Support	157	12.8%
Social Support	155	12.6%
Support with memory and Cognition	103	8.4%
Mental Health Support	96	7.8%
Not recorded	95	7.7%
Sensory Support	32	2.6%
	1227	

Enquiries by primary support reaso

	Count of referrals	%
Physical Support	332	52.8%
Learning Disability Support	88	14.0%
Social Support	60	9.5%
Support with memory and Cognition	54	8.6%
Not recorded	50	7.9%
Mental Health Support	26	4.1%
Sensory Support	19	3.0%
	629	

Concerns by abuse type

	Reported	%
Discriminatory	10	0.7%
Financial	239	16.1%
Institutional	11	0.7%
Neglect and Acts of Omission	378	25.4%
Physical	422	28.3%
Psychological	357	24.0%
Sexual	72	4.8%
including multiple	237	15.9%
Abuse types count for all alerts	1489	

Enquiries by abuse type

	Reported	%
Discriminatory	6	0.8%
Financial	159	####
Institutional	4	0.5%
Neglect and Acts of Omission	183	####
Physical	223	####
Psychological	177	####
Sexual	42	5.3%
including multiple	143	####
ɔuse types count for all referrals	794	

Concerns by relationship to adult at risk

	Count of ale	%
Known - Other Family Member	215	17.5%
Unknown - Individual/ Stranger	153	12.5%
Known - Partner	113	9.2%
Known - Main Family Carer	100	8.1%
Known - Neighbour/ Friend	89	7.3%
Known - but not related - Other Individual	81	6.6%
Private Sector - Residential Care Staff	80	6.5%
Known - Other Vulnerable Adult	73	5.9%
Unknown - Other Private Sector	61	5.0%
Public Sector - Domicilliary Care Staff	48	3.9%
Known - Social Care - Other	37	3.0%
Public Sector - Residential Care Staff	35	2.9%
Known - Secondary Health Care	23	1.9%
Known - Primary Health Care	21	1.7%
Known - Other Professional	15	1.2%
Known - Other Private Sector	14	1.1%
Unknown - Other Professional	14	1.1%
Unknown - Community Health Care	11	0.9%
Known - Community Health Care	10	0.8%
Unknown - Primary Health Care	5	0.4%
Known - Other Public Sector	4	0.3%
Private Sector - Self Directed Support Staff	4	0.3%
Voluntary/ 3rd Sector - Domicilliary Care Staff	4	0.3%
Known - Social Care - Social Worker/ Care Manager	3	0.2%
Unknown - Secondary Health Care	3	0.2%
Private Sector - Day Care	2	0.2%
Public Sector - Day Care	2	0.2%
Public Sector - Self Directed Support Staff	2	0.2%
Unknown - Other Public Sector	2	0.2%
Known - Police	1	0.1%
Unknown - Other Voluntary	1	0.1%
Unknown - Police	1	0.1%
Total	1227	

Enquiries by relationship to adult at risk

	Count of referral	%
Known - Other Family Member	121	19.2%
Known - Main Family Carer	65	10.3%
Known - Neighbour/ Friend	55	8.7%
Known - Partner	50	7.9%
Unknown - Individual/ Stranger	49	7.8%
Private Sector - Residential Care Staff	41	6.5%
Known - but not related - Other Individual	38	6.0%
Unknown - Other Private Sector	32	5.1%
Public Sector - Domicilliary Care Staff	29	4.6%
Known - Other Vulnerable Adult	28	4.5%
Public Sector - Residential Care Staff	24	3.8%
Known - Social Care - Other	23	3.7%
Known - Secondary Health Care	12	1.9%
Known - Other Professional	11	1.7%
Known - Other Private Sector	10	1.6%
Known - Primary Health Care	10	1.6%
Unknown - Community Health Care	4	0.6%
Known - Community Health Care	3	0.5%
Known - Other Public Sector	3	0.5%
Private Sector - Self Directed Support Staff	3	0.5%
Unknown - Other Professional	3	0.5%
Unknown - Primary Health Care	3	0.5%
Private Sector - Day Care	2	0.3%
Public Sector - Day Care	2	0.3%
Unknown - Secondary Health Care	2	0.3%
Voluntary/ 3rd Sector - Domicilliary Care Staff	2	0.3%
Known - Police	1	0.2%
Known - Social Care - Social Worker/ Care Manager	1	0.2%
Public Sector - Self Directed Support Staff	1	0.2%
Unknown - Other Public Sector	1	0.2%
Total	629	

Concerns by source

	Count of ale	
Social Care - Social Worker/Care Manager	217	17.7%
Health - Secondary Health staff	166	13.5%
Health - Primary Health/Community Health staff	159	13.0%
Social Care - Residential Care staff	129	10.5%
Other (including probation, anonymous, contract staff,	111	9.0%
Family member	88	7.2%
Social Care - Other	76	6.2%
Police	63	5.1%
Social Care - Domiciliary staff	49	4.0%
Self Referral	39	3.2%
Social Care - Day Care staff	38	3.1%
Housing	23	1.9%
Friend/neighbour	18	1.5%
London Ambulance Service	18	1.5%
Health - Mental Health staff ?? Joint Teams	12	1.0%
Social Care - Self-directed Care staff	7	0.6%
Care Quality Commission	5	0.4%
Education/Training/Workplace Establishment	5	0.4%
Other service user	4	0.3%

	Count of alert	%
Social Care - Social Worker/Care Manager	217	17.7%
Health - Secondary Health staff	166	13.5%
Health - Primary Health/Community Health staff	159	13.0%
Social Care - Residential Care staff	129	10.5%
Other (including probation, anonymous, contract staff,	111	9.0%
Family member	88	7.2%
Social Care - Other	76	6.2%
Police	63	5.1%
Social Care - Domiciliary staff	49	4.0%
Self Referral	39	3.2%
Social Care - Day Care staff	38	3.1%
Housing	23	1.9%
Friend/neighbour	18	1.5%
London Ambulance Service	18	1.5%
Health - Mental Health staff ?? Joint Teams	12	1.0%
Social Care - Self-directed Care staff	7	0.6%
Care Quality Commission	5	0.4%
Education/Training/Workplace Establishment	5	0.4%
Other service user	4	0.3%
Total	1227	

Enquiries by source

	Count of Referral	%
Social Care - Social Worker/Care Manager	126	20.0%
Health - Secondary Health staff	99	15.7%
Health - Primary Health/Community Health staff	67	10.7%
Family member	54	8.6%
Social Care - Residential Care staff	53	8.4%
Other (including probation, anonymous, contract staff	43	6.8%
Social Care - Other	37	5.9%
Police	29	4.6%
Social Care - Day Care staff	28	4.5%
Social Care - Domiciliary staff	27	4.3%
Self Referral	17	2.7%
Housing	14	2.2%
Friend/neighbour	9	1.4%
London Ambulance Service	9	1.4%
Social Care - Self-directed Care staff	5	0.8%
Care Quality Commission	4	0.6%
Health - Mental Health staff ?? Joint Teams	4	0.6%
Education/Training/Workplace Establishment	2	0.3%
Other service user	2	0.3%
Total	629	

Plan offered

Plan offered includes..	Count of plan items	%
Application of change appointee-ship		
Application of Court of Protection	4	0.5%
Civil action	2	0.3%
Community Care assessment and services	89	11.7%
Guardianship/use of Mental Health A	1	0.1%
Increased monitoring	94	12.4%
Management of access to finances	16	2.1%
Move to increase/different care	36	4.7%
No further action (NFA)	173	22.8%
Other	211	27.8%
Referral to advocacy scheme	12	1.6%
Referral to counselling/training	16	2.1%
Referral to MARAC	13	1.7%
Restriction or management of acces	43	5.7%
Review of self-directed support	13	1.7%
Vulnerable adult removed from property or service	35	4.6%
Plan items count	758	

Outcomes for alleged

	Count of plan items for alleged	%
Action by Care Quality Commission	12	1.7%
Action by contract compliance	28	3.9%
Action under the MHA 1983 and 2005	7	1.0%
Alleged perpetrator referred to PoVA List/ISA	8	1.1%
Community Care assessment and services for the alle	26	3.6%
Continued monitoring of alleged perpetrator	43	6.0%
Counselling/training/treatment	21	2.9%
Criminal prosecution/formal caution	17	2.4%
Disciplinary action against alleged perpetrator	23	3.2%
Exoneration	28	3.9%
Management of access to the Vulnerable Adult by the	34	4.7%
No further action (NFA)	266	37.0%
Not known	75	10.4%
Police action	72	10.0%
Referral to court mandated treatment	1	0.1%
Referral to MAPPA	1	0.1%
Referral to registration body	12	1.7%
Removal of alleged perpetrator from property or service	44	6.1%
Plan items count	718	

Safeguarding Concerns

		F	M	U	Total
18-64	18-64: Learning Disability Support	71	64		135
	18-64: Mental Health Support	55	20		75
	18-64: Not recorded	59	33		92
	18-64: Physical Support	70	47		117
	18-64: Sensory Support	9	5		14
	18-64: Social Support	73	18	1	92
	18-64: Support with memory and Cognition	17	18		35
18-64		354	205	1	560
65-74	65-74: Learning Disability Support	12	8		20
	65-74: Mental Health Support	5	4		9
	65-74: Not recorded				0
	65-74: Physical Support	46	38		84
	65-74: Sensory Support	3	1		4
	65-74: Social Support	21	8		29
	65-74: Support with memory and Cognition	10	8		18
65-74		97	67		164
75-84	75-84: Learning Disability Support	1			1
	75-84: Mental Health Support	6	2		8
	75-84: Not recorded	3			3
	75-84: Physical Support	132	62		194
	75-84: Sensory Support	2	5		7
	75-84: Social Support	22	3		25
	75-84: Support with memory and Cognition	22	13		35
75-84		188	85		273
85+	85+: Learning Disability Support				0
	85+: Mental Health Support	3	1		4
	85+: Not recorded				0
	85+: Physical Support	135	58		193
	85+: Sensory Support	2	5		7
	85+: Social Support	1	5		6
	85+: Support with memory and Cognition	13	2		15
85+		154	71		225
DOB unknown	DOB unknown: Learning Disability Support			1	1
	DOB unknown: Physical Support		1		1
	DOB unknown: Social Support	1	2		3
DOB unknown		1	3	1	5

		F	M	U	Total
	Total	794	431	2	1227
	Placed by other local authority	58	38		96
	Already known to CASSR	528	304		832

Safeguarding Enquiries

		F	M	Total
18-64	18-64: Learning Disability Support	42	32	74
	18-64: Mental Health Support	13	4	17
	18-64: Not recorded	26	21	47
	18-64: Physical Support	44	24	68
	18-64: Sensory Support	5	2	7
	18-64: Social Support	23	7	30
	18-64: Support with memory and Cognition	11	12	23
18-64		164	102	266
65-74	65-74: Learning Disability Support	8	5	13
	65-74: Mental Health Support	2	1	3
	65-74: Not recorded			0
	65-74: Physical Support	33	24	57
	65-74: Sensory Support	2	1	3
	65-74: Social Support	8	3	11
	65-74: Support with memory and Cognition	3	6	9
65-74		56	40	96
75-84	75-84: Learning Disability Support	1		1
	75-84: Mental Health Support	4	1	5
	75-84: Not recorded	2		2
	75-84: Physical Support	73	37	110
	75-84: Sensory Support	1	3	4
	75-84: Social Support	11	3	14
	75-84: Support with memory and Cognition	13	3	16
75-84		105	47	152
85+	85+: Learning Disability Support			0
	85+: Mental Health Support	1	1	2
	85+: Not recorded			0
	85+: Physical Support	67	30	97
	85+: Sensory Support	2	3	5
	85+: Social Support		5	5
	85+: Support with memory and Cognition	4	2	6
85+		74	41	115

		F	M	Total
	Total	399	230	629
	Placed by other local authority	35	21	56
	Already known to CASSR	273	164	437

of which Repeat Enquiries

		F	M	Totals
18-64	18-64: Learning Disability Support	15	8	23
	18-64: Mental Health Support	3	2	5
	18-64: Not recorded	1	1	2
	18-64: Physical Support	9	2	11
	18-64: Sensory Support	2		2
	18-64: Social Support	1		1
	18-64: Support with memory and Cognition	3	7	10
18-64		34	20	54
65-74	65-74: Learning Disability Support	4	1	5
	65-74: Mental Health Support			
	65-74: Not recorded			
	65-74: Physical Support	4	7	11
	65-74: Sensory Support			
	65-74: Social Support			
	65-74: Support with memory and Cognition		3	3
65-74		8	11	19
75-84	75-84: Learning Disability Support			
	75-84: Mental Health Support	1		1
	75-84: Not recorded			
	75-84: Physical Support	13	4	17
	75-84: Sensory Support		1	1
	75-84: Social Support	2		2
	75-84: Support with memory and Cognition	2		2
75-84		18	5	23
85+	85+: Learning Disability Support			
	85+: Mental Health Support			
	85+: Not recorded			
	85+: Physical Support	9	4	13
	85+: Sensory Support	1	2	3
	85+: Social Support			
	85+: Support with memory and Cognition			
85+		10	6	16

		F	M	Totals
	Total	70	42	112
	Placed by other local authority	8	3	11
	Already known to CASSR	56	34	90

Completed Enquiries

		F	M	Total
18-64	18-64: Learning Disability Support	42	28	70
	18-64: Mental Health Support	12	4	16
	18-64: Not recorded	17	17	34
	18-64: Physical Support	43	19	62
	18-64: Sensory Support	5	1	6
	18-64: Social Support	21	6	27
	18-64: Support with memory and Cognition	11	11	22
18-64		151	86	237
65-74	65-74: Learning Disability Support	8	4	12
	65-74: Mental Health Support	2	1	3
	65-74: Not recorded			0
	65-74: Physical Support	31	20	51
	65-74: Sensory Support	3	1	4
	65-74: Social Support	7	4	11
	65-74: Support with memory and Cognition	2	4	6
65-74		53	34	87
75-84	75-84: Learning Disability Support	1		1
	75-84: Mental Health Support	5	1	6
	75-84: Not recorded	2		2
	75-84: Physical Support	59	32	91
	75-84: Sensory Support		3	3
	75-84: Social Support	10	2	12
	75-84: Support with memory and Cognition	9	4	13
75-84		86	42	128
85+	85+: Learning Disability Support			0
	85+: Mental Health Support	1	1	2
	85+: Not recorded			0
	85+: Physical Support	58	25	83
	85+: Sensory Support	2	2	4
	85+: Social Support	1	4	5
	85+: Support with memory and Cognition	4	1	5
85+		66	33	99

		F	M	Total
	Total	356	195	551
	Placed by other local authority	38	24	62
	Already known to CASSR	267	148	415

Safeguarding Conc

		18-64 F	18-64 M	18-64 U	65+ F	65+ M	B unkno F	B unkno M	B unkno U	Totals
Asian or Asian British	Afghan	2			1					3
	Any other Asian background	22	14		22	8				66
	Bangladeshi	3	1		1					5
	Chinese				2					2
	Did not wish to reply		2							2
	Form not completed		1							1
	Indian	45	23		49	25		1		143
	Pakistani	17	3		1	2				23
	Sri Lankan	7			1	2				10
Asian or Asian British	Totals	96	44		77	37		1		**255**
Black or Black British	African	8	4		7	1				20
	Any other Black background	11	2		1	1				15
	Caribbean	17	16		19	8				60
	Somali									0
Black or Black British	Totals	36	22		27	10				**95**
Mixed background	Any other mixed background	23	6							29
	White and Asian	3			4					7
	White and Black African	1								1
	White and Black Caribbean	2	3							5
Mixed background	Totals	29	9		4					**42**
Not Stated	Did not wish to reply	2			4	1				7
	Form not completed	11	4		3	4		1	1	24
Not Stated	Totals	13	4		7	5		1	1	**31**
Other Ethnic background	Any other ethnic group	32	7		5					44
	Arab	3	1							4
	Form not completed				2					2
	Iranian									0
her Ethnic background	Totals	35	8		7					**50**
hite or White British	Albanian									0
	Any other White background	39	19		58	20	1			137
	English	88	87		228	122		1		526
	Gypsy									0
	Irish	14	11		31	29				85
	Irish Traveller									0
	Polish	4	1	1						6
	Romanian									0
	Scottish									0
	Welsh									0
White or White British	Totals	145	118	1	317	171	1	1		**754**

		F	M	U	Total
	Total	794	431	2	##
	Placed by other local authority	58	38		96
	Already known to CASSR	528	304		##

Safeguarding Enquiries

		18-64 F	18-64 M	65+ F	65+ M	Totals
Asian or Asian British	Afghan					0
	Any other Asian background	13	11	12	5	41
	Bangladeshi			1		1
	Chinese			2		2
	Form not completed		1			1
	Indian	21	11	30	12	74
	Pakistani	9	1		2	12
	Sri Lankan	3		1	1	5
Asian or Asian British	Totals	46	24	46	20	**136**
Black or Black British	African	3	2	3	1	9
	Any other Black background	3	2	1	1	7
	Caribbean	8	8	11	6	33
	Somali					0
Black or Black British	Totals	14	12	15	8	**49**
Mixed background	Any other mixed background	10	2			12
	White and Asian	3		3		6
	White and Black African	1				1
	White and Black Caribbean	2	1			3
Mixed background	Totals	16	3	3		**22**
Not Stated	Did not wish to reply	1		2	1	4
	Form not completed	1	1	1	1	4
Not Stated	Totals	2	1	3	2	**8**
Other Ethnic background	Any other ethnic group	14	5	1		20
	Arab					0
	Iranian					0
Other Ethnic background	Totals	14	5	1		**20**
White or White British	Albanian					0
	Any other White background	13	7	30	13	63
	English	49	47	120	71	287
	Gypsy					0
	Irish	7	3	17	14	41
	Irish Traveller					0
	Polish	3				3
	Romanian					0
	Scottish					0
	Welsh					0
White or White British	Totals	72	57	167	98	**394**

		F	M	Total
	Total	##	230	629
	Placed by other local authority	35	21	56
	Already known to CASSR	##	164	437

of which Repeat Enquiries

		18-64 F	18-64 M	65+ F	65+ M	Totals
Asian or Asian British	Afghan					
	Any other Asian background	3	2			5
	Bangladeshi					
	Chinese			1		1
	Form not completed					
	Indian	3		2	3	8
	Pakistani	2				2
	Sri Lankan					
Asian or Asian British	Totals	8	2	3	3	**16**
Black or Black British	African					
	Any other Black background		1			1
	Caribbean			2	3	2	7
	Somali					
Black or Black British	Totals		3	3	2	**8**
Mixed background	Any other mixed background	1				1
	White and Asian			2		2
	White and Black African					
	White and Black Caribbean					
Mixed background	Totals	1		2		**3**
Not Stated	Did not wish to reply					
	Form not completed					
Not Stated	Totals					
Other Ethnic background	Any other ethnic group	1				1
	Arab					
	Iranian					
Other Ethnic background	Totals	1				**1**
White or White British	Albanian					
	Any other White background	5	1	9	3	18
	English	15	13	15	9	52
	Gypsy					
	Irish	3	1	4	5	13
	Irish Traveller					
	Polish	1				1
	Romanian					
	Scottish					
	Welsh					
White or White British	Totals	24	15	28	17	**84**

		F	M	Totals
	Total	70	42	112
	Placed by other local authority	8	3	11
	Already known to CASSR	56	34	90

Completed Referrals

		18-64 F	18-64 M	65+ F	65+ M	Totals
Asian or Asian British	Afghan					0
	Any other Asian background	11	9	10	4	34
	Bangladeshi			1		1
	Chinese			2		2
	Form not completed		1			1
	Indian	23	11	29	12	75
	Pakistani	8	1		2	11
	Sri Lankan	2		1	1	4
Asian or Asian British	Totals	44	22	43	19	**128**
Black or Black British	African	2	2	2	1	7
	Any other Black background	4	2	1	1	8
	Caribbean	5	7	9	5	26
	Somali					0
Black or Black British	Totals	11	11	12	7	**41**
Mixed background	Any other mixed background	7	3			10
	White and Asian	3		2		5
	White and Black African					0
	White and Black Caribbean	2	1			3
Mixed background	Totals	12	4	2		**18**
Not Stated	Did not wish to reply			1	1	2
	Form not completed	1	1	1	1	4
Not Stated	Totals	1	1	2	2	**6**
Other Ethnic background	Any other ethnic group	12	3	1		16
	Arab					0
	Indian	1				1
	Iranian					0
Other Ethnic background	Totals	13	3	1		**17**
White or White British	Albanian					0
	Any other White background	10	6	27	12	55
	English	52	35	103	58	248
	Gypsy					0
	Irish	5	4	15	11	35
	Irish Traveller					0
	Polish	3				3
	Romanian					0
	Scottish					0
	Welsh					0
White or White British	Totals	70	45	145	81	**341**

		F	M	Total
	Total	##	195	551
	Placed by other local authority	38	24	62
	Already known to CASSR	##	148	415

Safeguarding Concerns: Source

	18-64: Learning Disability Support	18-64: Mental Health Support	18-64: Not recorded	18-64: Physical Support	18-64: Sensory Support	18-64: Social Support	18-64: Support with memory and Cognition	65-74: Older	75-84: Older	85+: Older	DOB unknown: Learning Disability Support	DOB unknown: Physical Support	DOB unknown: Social Support	Totals
Care Quality Commission	2								1	2				5
Education/Training/Workplace Establishment	1	1				3								5
Family member	3	3	6	11		3	4	14	26	17			1	88
Friend/neighbour		2		1		3		3	4	5				18
Health - Mental Health staff ?? Joint Teams	2	3		2		1		1	3					12
Health - Primary Health/Community Health staff	4	10	2	15	2	20	4	24	40	37			1	159
Health - Secondary Health staff	9	16	34	17	2	14	5	14	29	25		1		166
Housing	1	1	1	1				6	10	3				23
London Ambulance Service		2	1	2		3		2	1	7				18
Other (including probation, anonymous, contract staff, MAPA, MARCA)	11	13	33	8		7	5	9	10	15				111
Other service user	1							2		1				4
Police	6	3	4	4		4	1	13	22	6				63
Self Referral	2	5	4	6	1	9	4	2	3	3				39
Social Care - Day Care staff	9	3		4			3	8	7	4				38
Social Care - Domiciliary staff	5			8	2	1	1	9	17	6				49
Social Care - Other	15	4	3	6	1	5	2	7	17	15			1	76
Social Care - Residential Care staff	28	2		11	2	3	2	17	27	37				129
Social Care - Self-directed Care staff	2					3	1	1						7
Social Care - Social Worker/Care Manager	34	7	4	21	4	13	3	32	56	42	1			217
	135	75	92	117	14	92	35	164	273	225	1	1	3	1227

Concerns by abuse type: referral may be appear more than once if multiple abuse types appl

Abuse type	Reported	%
Discriminatory	10	0.7%
Domestic violence	4	0.3%
Financial	239	16.1%
Institutional	11	0.7%
Modern slavery		
Neglect and Acts of Omission	378	25.4%
Physical	422	28.3%
Psychological	357	24.0%
Self neglect	5	0.3%
Sexual	72	4.8%
Sexual exploitation	9	0.6%
including multiple	237	15.9%
Abuse types count for all concerns	1489	

	18-64 F	18-64 M	18-64 U	65-74 F	65-74 M	75-84 F	75-84 M	85+ F	85+ M	DOB unknown F	DOB unknown M	DOB unknown U	Total
Discriminatory	4	2				1		2	1				10
Domestic violence	3	1											4
Financial	40	44		22	23	44	18	31	17				239
Institutional	2	1		1		2	2	1	2				11
Modern slavery													
Neglect and Acts of Omission	52	52		32	22	67	33	79	41				378
Physical	162	61	1	41	13	63	23	42	13	1	1	1	422
Psychological	133	67		24	21	53	20	26	10	1	2		357
Self neglect	1	1			1		1	1					5
Sexual	45	13		5	1	6		1	1				72
Sexual exploitation	7	2											9
including multiple	77	33		23	13	43	10	24	13	1			237
Total	354	205	1	97	67	188	85	154	71	1	3	1	1227

	18-64: Learning Disability Support	18-64: Mental Health Support	18-64: Not recorded	18-64: Physical Support	18-64: Sensory Support	18-64: Social Support	Support with memory and Cognition	65-74: Older	75-84: Older	85+: Older	DOB unknown: Learning Disability Support	DOB unknown: Physical Support	DOB unknown: Social Support	Total
Discriminatory	1			2			3		1	3				10
Domestic violence														
Financial	19	16	9	22	2	7	9	45	62	48				239
Institutional	1	1					1	1	4	3				11
Modern slavery														
Neglect and Acts of Omission	27	12	13	40	1	2	9	54	100	120				378
Physical	49	33	34	33	9	57	9	54	86	55	1	1	1	422
Psychological	41	27	28	38	5	52	9	45	73	36			3	357
Self neglect														
Sexual	20	4	15	9		9	1	6	6	2				72
Sexual exploitation														
including multiple	21	17	5	26	3	33	5	36	53	37			1	237
Total	135	75	92	117	14	92	35	164	273	225	1	1	3	1227

Concerns by location

	18-64	65-74	75-84	85+	DOB unknown	Total
Acute Hospital	15	1	4	4		24
Acute Hospital; Community Hospital			1			1
Community Hospital	6	3	7	2		18
Community Hospital; Other Health Setting (i				1		1
Day Centre/Service	6	1	1	2		10
Education/Training/Workplace Establishmen	6			1		7
Home of alleged	7	2				9
Home of alleged; Other	1					1
Mental Health Inpatient Setting	18	2	1	1		22
Not known	29	1	2	1		33
Nursing Care Home - Permanent	16	9	25	43		93
Nursing Care Home - Permanent; Communit				1		1
Nursing Care Home - Permanent; Supported				1		1
Nursing Care Home - Temporary		3	7	6		16
Other	21	6	4			31
Other Health Setting (including Hospice)	3		1	2		6
Other; Not known	1					1
Own home	322	104	173	116	4	719
Own home; Acute Hospital				1		1
Own home; Community Hospital			1	1		2
Own home; Home of alleged			1			1
Own home; Mental Health Inpatient Setting				1		1
Own home; Nursing Care Home - Permanen	1					1
Own home; Other	3					3
Own home; Public Place	3	2				5
Own home; Public Place; Home of alleged	1					1
wn home; Public Place; Other		1				1
wn home; Supported Accommodation	1	2				3
ublic Place	20	2	3			25
esidential Care Home - Permanent	48	15	32	33		128
Residential Care Home - Permanent; Acute H			1			1
Residential Care Home - Permanent; Reside					1	1
Residential Care Home - Temporary	1	2	4	2		9
Supported Accommodation	30	8	5	6		49
Supported Accommodation; Home of allege	1					1
al	560	164	273	225	5	1227

Enquiries by location

	Learning Disability Support	Mental Health Support	Not recorded	Physical Support	Sensory Support	Social Support	Support with memory and Cognition	Total
Acute Hospital			8	4			1	13
Community Hospital	1			4		1		6
Community Hospital; Other Health Setting (including Hospice)				1				1
Day Centre/Service	3			2			1	6
Education/Training/Workplace Establishment	2		1			1		4
Home of alleged	1			1		3		5
Mental Health Inpatient Setting			11	1				12
Not known	1	1	1	2		2		7
Nursing Care Home - Permanent	4	1		41	2	1	2	51
Nursing Care Home - Permanent; Community Hospital; Other						1		1
Nursing Care Home - Temporary				6			1	7
Other	3		1	5	2	5		16
Other Health Setting (including Hospice)							1	1
Own home	33	21	24	209	12	40	33	372
Own home; Community Hospital				1				1
Own home; Home of alleged						1		1
Own home; Nursing Care Home - Permanent				1				1
Own home; Other	1		1	1				3
Own home; Public Place				1				1
Own home; Public Place; Home of alleged	1							1
Own home; Public Place; Other				1				1
Own home; Supported Accommodation	1							1
Public Place	5		1	2		1	3	12
Residential Care Home - Permanent	21	3	1	30	2	3	10	70
Residential Care Home - Permanent; Acute Hospital				1				1
Residential Care Home - Temporary				3			1	4
Supported Accommodation	10		1	15	1	1	1	29
Supported Accommodation; Home of alleged	1							1
Total	88	26	50	332	19	60	54	629

Concerns by funding arrangement

	18-64 F	18-64 M	18-64 U	65-74 F	65-74 M	75-84 F	75-84 M	85+ F	85+ M	DOB unknown F	DOB unknown M	DOB unknown U	Total
Funded by another Local Authority	13	19		5	3	11	2	3	1		1	1	59
Funded by another Local Authority; Funde	1						1	1					3
Funded by Harrow Council	88	77		29	29	83	33	73	37				449
Funded by Harrow Council; Funded by an									1				1
Funded by Harrow Council; Funded by an				1									1
Funded by Harrow Council; Funded by NH	2	2			2								6
Funded by Harrow Council; Not in receipt	1	3		1	2	1	1	1					10
Funded by Harrow Council; Self funded		1											1
Funded by NHS Continuing Health Care	2	6		1	1		5	9	1				25
Funded by NHS Continuing Health Care; S		1							1				2
Not in receipt of Funded Care	146	48	1	42	21	65	27	33	17	1	2		403
Not recorded	101	48		15	7	13	10	13	8				215
Self funded				3	2	15	6	21	5				52
Total	354	205	1	97	67	188	85	154	71	1	3	1	1227

Safeguarding concerns: alleged perpetr

		18-64 F	18-64 M	18-64 U	65-74 F	65-74 M	75-84 F	75-84 M	85+ F	85+ M	DOB unknown F	DOB unknown M	DOB unknown U	Total
Known - but not related - Other Individual		30	18		2	2	6	5	6	9	1	1	1	81
Known - Community Health Care		2			1		2		4	1				10
Known - Main Family Carer		19	14		13	1	28	7	14	4				100
Known - Neighbour/ Friend		27	17		9	8	15	5	6	1		1		89
Known - Other Family Member		78	32		24	6	35	12	23	5				215
Known - Other Private Sector		3	3				3	3	1	1				14
Known - Other Professional		3	4		1		3		3	1				15
Known - Other Public Sector			1		1		1	1						4
Known - Other Vulnerable Adult		22	25		5	5	5	2	9					73
Known - Partner		67	7	1	7	6	13	5	4	3				113
Known - Police			1											1
Known - Primary Health Care			3		1	4	4	4		5				21
Known - Secondary Health Care		9	1			1	3	3	3	3				23
Known - Social Care - Other		10	7		1	1	6	1	8	3				37
Known - Social Care - Social Worker/ Care Manager		1							1	1				3
Private Sector - Day Care		1								1				2
Private Sector - Residential Care Staff		10	11		4	5	12	12	17	8		1		80
Private Sector - Self Directed Support Staff			1		1			1		1				4
Public Sector - Day Care							1			1				2
Public Sector - Domicilliary Care Staff		7	4		6	5	8	2	11	5				48
Public Sector - Residential Care Staff		5	5		2	3	3	3	10	4				35
Public Sector - Self Directed Support Staff						1	1							2
Unknown - Community Health Care		3			1		3		3	1				11
Unknown - Individual/ Stranger		47	34		8	10	18	11	18	7				153
Unknown - Other Private Sector		4	11		8	4	14	5	12	3				61
Unknown - Other Professional		3	4		2	1	2	1		1				14
Unknown - Other Public Sector						1	1							2
Unknown - Other Voluntary								1						1
Unknown - Police		1												1
Unknown - Primary Health Care		1				1			1	2				5
Unknown - Secondary Health Care		1	1				1							3
Voluntary/ 3rd Sector - Domicilliary Care Staff			1			2		1						4
	Total	354	205	1	97	67	188	85	154	71	1	3	1	1227
Lives with vulnerable adult		108	42	1	40	12	58	13	32	8				314
Is main carer		41	28		21	7	44	20	31	14		1		207

		18-64: Learning Disability Support	18-64: Mental Health Support	18-64: Not recorded	18-64: Physical Support	18-64: Sensory Support	18-64: Social Support	18-64: Support with memory and Cognition	65-74: Older	75-84: Older	85+: Older	DOB unknown: Learning Disability Support	DOB unknown: Physical Support	DOB unknown: Social Support	Total
Known - but not related - Other Individual		15	8	1	8	1	13	2	4	11	15	1		2	81
Known - Community Health Care					2				1	2	5				10
Known - Main Family Carer		13	1		11	4	3	1	14	35	18				100
Known - Neighbour/ Friend		16	8	3	3	2	7	5	17	20	7			1	89
Known - Other Family Member		13	14	22	31	2	24	4	30	47	28				215
Known - Other Private Sector			1		4			1		6	2				14
Known - Other Professional		3		2	1			1	1	3	4				15
Known - Other Public Sector		1							1	2					4
Known - Other Vulnerable Adult		16	2	17	4		3	5	10	7	9				73
Known - Partner		5	15	10	11		30	4	13	18	7				113
Known - Police							1								1
Known - Primary Health Care					3				5	8	5				21
Known - Secondary Health Care		1	1	5	3				1	6	6				23
Known - Social Care - Other		7	1	1	4		3	1	2	7	11				37
Known - Social Care - Social Worker/ Care Manager		1									2				3
Private Sector - Day Care		1									1				2
Private Sector - Residential Care Staff		13			4			4	9	24	25		1		80
Private Sector - Self Directed Support Staff		1							1	1	1				4
Public Sector - Day Care										1	1				2
Public Sector - Domicilliary Care Staff		3		1	5	1		1	11	10	16				48
Public Sector - Residential Care Staff		5		1	3			1	5	6	14				35
Public Sector - Self Directed Support Staff									1	1					2
Unknown - Community Health Care			2					1	1	3	4				11
Unknown - Individual/ Stranger		15	18	26	11	3	6	2	18	29	25				153
Unknown - Other Private Sector		6	3	1	1	1	2	1	12	19	15				61
Unknown - Other Professional			1	1	4			1	3	3	1				14
Unknown - Other Public Sector									1	1					2
Unknown - Other Voluntary										1					1
Unknown - Police					1										1
Unknown - Primary Health Care					1				1		3				5
Unknown - Secondary Health Care				1	1					1					3
Voluntary/ 3rd Sector - Domicilliary Care Staff					1				2	1					4
	Total	135	75	92	117	14	92	35	164	273	225	1	1	3	1227
Lives with vulnerable adult		30	21	20	32	1	41	6	52	71	40				314
Is main carer		22	4	16	15	1	3	8	28	64	45		1		207

Conclusion

	Inconclusive	Investigation ceased at individual`s request	Not substantiated	Substantiated - fully	Substantiated - partially		Totals
18-64: Learning Disability Support	12	3	26	17	3	9	70
18-64: Mental Health Support	3		3	7	2	1	16
18-64: Not recorded	10		8	9	6	1	34
18-64: Physical Support	10	3	16	14	9	10	62
18-64: Sensory Support	1	3	2				6
18-64: Social Support	4	4	5	8	2	4	27
18-64: Support with memory and C	3		5	7	6	1	22
65-74: Older	10	4	36	13	7	17	87
75-84: Older	19	9	43	22	9	26	128
85+: Older	11	4	37	21	7	19	99
	83	30	181	118	51	88	551

		Inconclusive	Investigation ceased at individual`s request	Not substantiated	Substantiated - fully	Substantiated - partially		Total
Asian or Asian British	Any other Asian background	4		9	12	3	6	34
Asian or Asian British	Bangladeshi						1	1
Asian or Asian British	Chinese			2				2
Asian or Asian British	Form not completed			1				1
Asian or Asian British	Indian	12	5	26	13	5	14	75
Asian or Asian British	Pakistani	4	1	1	3		2	11
Asian or Asian British	Sri Lankan	1	1				2	4
Black or Black British	African	3		3		1		7
Black or Black British	Any other Black background	2		2	3	1		8
Black or Black British	Caribbean	5	2	9	3	3	4	26
Mixed background	Any other mixed background	4		3	3			10
Mixed background	White and Asian			2	2	1		5
Mixed background	White and Black Caribbean			2			1	3
Not Stated	Did not wish to reply			1			1	2
Not Stated	Form not completed						4	4
Other Ethnic background	Any other ethnic group	6	1		7	2		16
Other Ethnic background	Indian			1				1
White or White British	Any other White background	7	6	16	10	9	7	55
White or White British	English	32	13	87	53	23	40	248
White or White British	Irish	3	1	16	6	3	6	35
White or White British	Polish				3			3
	Total	83	30	181	118	51	88	551

Plan offered: cases may appear multiple times

	18-64: Learning Disability Support	18-64: Mental Health Support	18-64: Not recorded	18-64: Physical Support	18-64: Sensory Support	18-64: Social Support	18-64: Support with memory and Cognition	65-74: Older	75-84: Older	85+: Older	Totals
Application of change appointee-ship											
Application of Court of Protection				1					2	1	4
Civil action									1	1	2
Community Care assessment and services	14	1		10	2	3	5	11	24	19	89
Guardianship/use of Mental Health Act				1							1
Increased monitoring	21	3	9	7		6	6	9	19	14	94
Management of access to finances	3		1	2				4	3	3	16
Move to increase/different care	3	1	4	2		1	3	5	9	8	36
No further action (NFA)	23	2		17	2	14	3	30	47	35	173
Other	23	8	11	26	2	8	8	34	50	41	211
Referral to advocacy scheme	5			1	2	1		1	2		12
Referral to counselling/training	3	1	1	3	2	1	1	2	2		16
Referral to MARAC	2		1	3	1	2	1	2	1		13
Restriction or management of access	10		3	8		2	1	9	6	4	43
Review of self-directed support	3			3			1	1	3	2	13
Vulnerable adult removed from property or service	5	1	5	5		2		5	6	6	35
Totals	70	16	34	62	6	27	22	87	128	99	551

Serious case reviews?

Serious case review	NO serious case review	OTAL COMPLETED REFERRAL
0	551	551

Protection plan accepted

	18-64: Learning Disability Support	18-64: Mental Health Support	18-64: Not recorded	18-64: Physical Support	18-64: Sensory Support	18-64: Social Support	18-64: Support with memory and	65-74: Older	75-84: Older	85+: Older	Totals
NOT WAREHOUSED	70	16	34	62	6	27	22	87	128	99	551
Totals	70	16	34	62	6	27	22	87	128	99	551

Safeguarding: outcome for alleged

	18-64: Learning Disability Support	18-64: Mental Health Support	18-64: Not recorded	18-64: Physical Support	18-64: Sensory Support	18-64: Social Support	18-64: Support with memory and Cognition	65-74: Older	75-84: Older	85+: Older	Totals
Action by Care Quality Commission									4	8	12
Action by Contract Compliance	2			1		1		1	13	10	28
Action under Mental Health Act	1			1		1		1	2	1	7
Community Care Assessment	5			3		1	1	6	5	5	26
Continued Monitoring	7	2	4	5	1	1	1	3	12	7	43
Counselling/Training/Treatment	4	1		3				5	4	4	21
Criminal Prosecution/ Formal Caution	3	1	1		1	1	2	5	2	1	17
Disciplinary Action	2		1	5		1	1	1	4	8	23
Exoneration	2			1				7	9	9	28
Management of access to the Vulnerable Adult	9		4	4		1	1	4	7	4	34
No Further Action	39	6	2	24	2	15	7	47	70	54	266
Not Known	2	4	15	11	1	3	9	6	17	7	75
Police Action	10	2	4	13	3	7	2	12	15	4	72
Referral to Court Mandated Treatment	1										1
Referral to MAPPA								1			1
Referral to Registration Body	2			1				1	3	5	12
Referred to PoVA List/Independent Safeguarding Authority	1			2					2	3	8
Removal from property or Service	6		3	5		5	1	10	5	9	44
Total	70	16	34	62	6	27	22	87	128	99	551

Appendix 2 Training statistics 2014 - 2015

Formal Training – Safeguarding Multi-agency programme	**2014-15**
Harrow Council Internal	224
Health	67
Statutory (other)	9
Private	565
Voluntary	250
Total:	**1115**

Booked	1337
Attended	1115
Cancelled	140
No Shows	82

Cancellations / No Shows	**2014-15 Cancellations**	**2014-15 No Shows**
Harrow Council Internal	28	31
Health	18	4
Statutory (other)	0	0
Private	63	29
Voluntary	31	18
Total Cancelled (formal training)	**140**	**82**

e-Learning

No. of completed courses	**66**
Internal (Harrow Council) completions	12
External completions	54

SGA Team Briefing Sessions

Age UK Volunteers	8
Asian Day Centre	41
Delegation of Swedish Visitors - ASB & SGA - Working together	10
Deprivation of Liberty Safeguards (DoLS) Briefings	171
Members Briefings	35
Neighbourhood Champions	16
RSPCA Volunteers	12
Dental Practices	15
GP Briefings	60
GP Surgeries (Clinical & Non-Clinical Staff)	78

Best Practice Workshops

Dignity & Respect in Care - WEAAD 2014	70
Older People Health Day (Professionals)	40
RSPCA, LSAB & LSCB - Recognising the Links	63
Unwise Decisions, Mental Capacity & Safeguarding	21
Keeping Safe in Harrow - Choices For All event	55

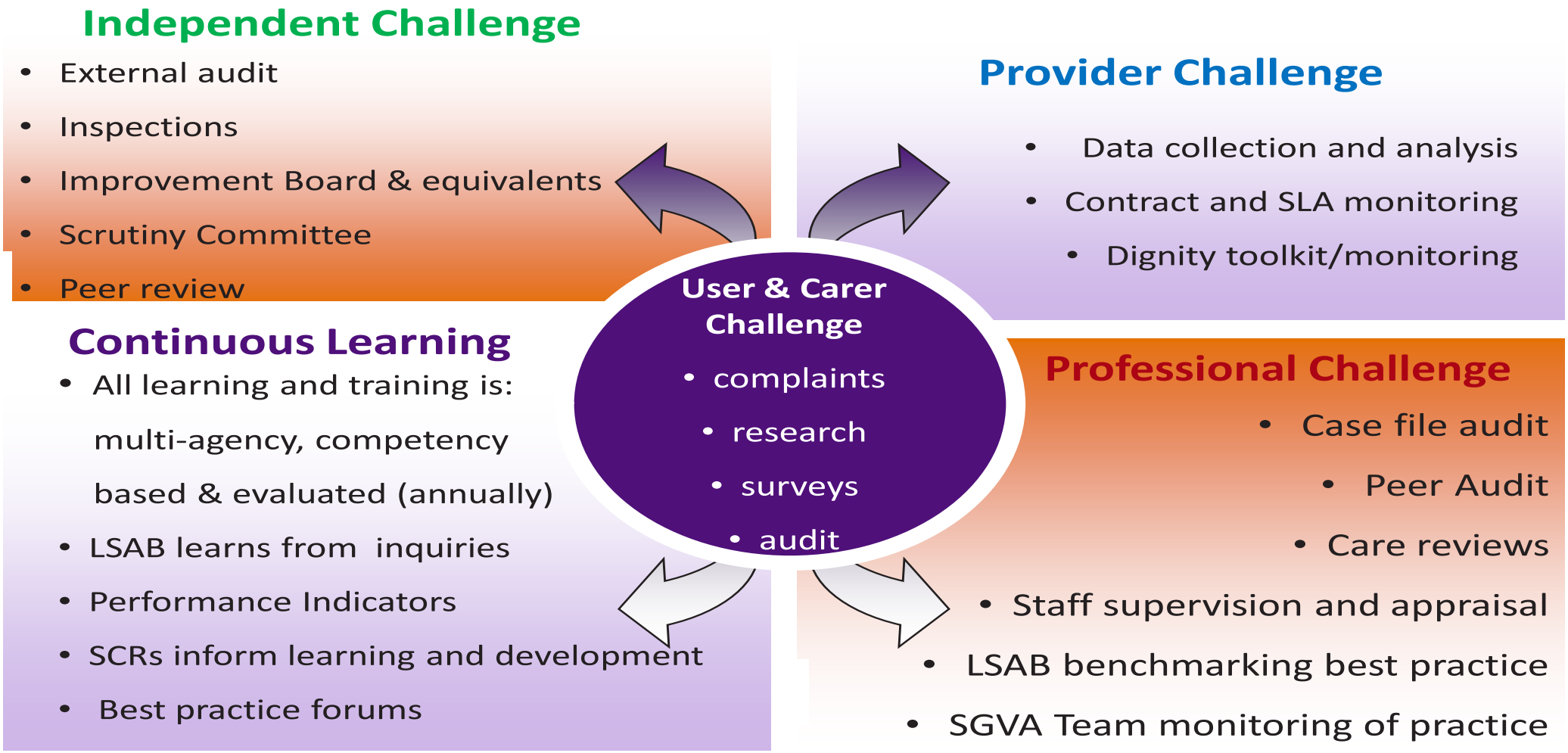
Service user briefings/community events

Older People Health Day	210
Marlborough Hill Day Centre / Wiseworks	38
MIND Service Users & Volunteers	10
Carers Briefing	9

Total across all events **2143**

Appendix 3

Safeguarding Vulnerable Adults at Risk in Harrow
Quality Assurance Framework



Appendix 4 Safeguarding Adults Peer Review - Action Plan as at March 2015

Standard	Peer Review Team Recommendation	Action (and timescale)
<u>Key theme:</u> Outcomes for and the experiences of people who use services		
1.3 The council demonstrates improved safeguarding outcomes alongside wider community safety improvements	Systematically capture the fact that people have been asked the outcomes they want and the extent that they are realised. This will focus practice even more and give the Board information about how effective they are	• continue to report on the findings of the independent social worker's interviews with users which checks that desired outcomes have been met (completed and ongoing) • ask the independent file auditor to check (in the next round of audits) that outcomes were clear at the start of the SGA investigation and checked with the user at case conference stage (completed)
	Re-focus on outcomes (rather than outputs or conclusions)	• ask LSAB members to ensure that all annual report and other relevant updates are outcome focused (completed)
	Getting through the 'front door' of Access Harrow (AH) can be difficult	• ask AH to review the telephone responses to calls (completed) • consider an LSAB led "mystery shopping" exercise (completed) • include as a standing agenda item at the quarterly SGA service meetings with AH (completed and ongoing)

	Access to justice is challenging here as elsewhere, but that shouldn't stop partners trying to address this	• amend FWi such that the safeguarding adult episode cannot be closed until a mandatory "prompt" about Police involvement has been answered (completed) • ensure this issue is covered adequately in the new 2014/2015 SGA training programme (completed) • continue to track progress against national performance at the LSAB meetings (completed and ongoing)
Key theme: Service delivery/effective practice, performance and resource management		
Service delivery and effective practice		
6.1 The council has robust and effective service delivery that makes safeguarding everybody's business	Further work on Mental Capacity Act, Human Rights Act and Domestic Violence legislation, case law and approaches would be beneficial	• run annual legal updates either as specific events or as part of other training sessions (completed and ongoing) • register relevant front line staff and managers with legal newsletters (completed) • focus enough of the new 2014/2015 SGA training programme on these areas (completed)

Performance and Resource Management		
7.1 Services are held accountable through performance measures, including quality measures, towards the outcomes for people in the strategy	There is a lot of council data. It could be enhanced by a focus on outcomes from practice and greater interrogation and analysis	• embed use of the new partner agency feedback template at all LSAB meetings from March 2014 (completed)
	There is scope to address more systematically, across the council and NHS commissioners, CQC and the Quality Surveillance Group, care quality issues and provider intelligence The council could encourage providers to engage more proactively with their own learning and development and share their own QA processes	• add Provider quality reports to the LSAB forward agenda (completed) • consider a "part 2" confidential section to Board meetings if business sensitive discussions can't be held at "open" meetings (this was discussed at the annual review day and may need further consideration) • ensure that the Council and CCG are discussing quality assurance processes with Providers at contract monitoring meetings (completed) • encourage Providers to share best practice at the Provider Forum (completed)
	IT is slow	• raise formally within the Council (completed)

Key theme: Working together		
8.1 There is multi-agency commitment to safeguarding	Strategic leadership and commitment from key statutory partners (on the board and in their respective organisations) will be critical to safeguarding Harrow citizens	• revisit compliance with signing of LSAB Partnership Agreements (completed) • reflect on membership and attendance as part of the 2013/2014 annual review process (completed)
	In their leadership role the council should consider how it brings partners into owning safeguarding (rather than seeing it as council business they are helping with)	• as agreed at the 2013 event, use an independent facilitator at the 2014 LSAB annual review day to ensure sufficient challenge of all Board members (completed)
	The Board should consider how it exerts a preventative function to ensure that people are not harmed by poor health, care or police responses	• ensure that the revised 2014 – 2017 "Promotion of Dignity and Prevention" Strategy is agreed by the LSAB in March 2014 and the responsible sub-group is fully representative of all the partner agencies (completed) • using the NHS audit tool work as a benchmark, continue to focus on ensuring that all GP surgeries have had recent awareness raising sessions (completed and ongoing) • analyse the 2013/14 mental health statistics and support CNWL in addressing any arising actions (completed and ongoing)
	The Board should consider how it brings together the data and intelligence its partners have in order to identify and manage risks in Harrow	See section 7.1 above

Appendix 5

LSAB Membership (as at 31st March 2015)

LSAB Member	Organisation
Samuel Abdullahi	Brent and Harrow Trading Standards
Jason Antrobus	Harrow Clinical Commissioning Group (CCG)
Paul Bushell	London Ambulance Service
Toni Burke	Harrow Council Housing Department
Richard Claydon	London Fire Service
Kim Cox (Tanya Paxton from March 2015)	CNWL Mental Health NHS Foundation Trust
Cllr Margaret Davine	Elected Councillor and Portfolio Holder – Harrow Council
Jonathan Davies	London North West Healthcare NHS Trust (hospital services)
Dr Julie-Anne Dowie	Royal National Orthopaedic Hospital (RNOH)
Professor Paul Fish	Royal National Orthopaedic Hospital (RNOH)
Cllr Pamela Fitzpatrick	Elected Councillor, Harrow Council
Bernie Flaherty (Chair)	Adult Social Services, Harrow Council
Mark Gillham	Mind in Harrow
Dr Lawrence Gould	Harrow CCG
Sherin Hart	Private sector care home provider representative
Nigel Long	Harrow Association of Disability
Colin Morris	Department of Work and Pensions
Sarah Crouch	Public Health, Harrow Council
Patrick Laffey	London North West Healthcare NHS Trust (community services)

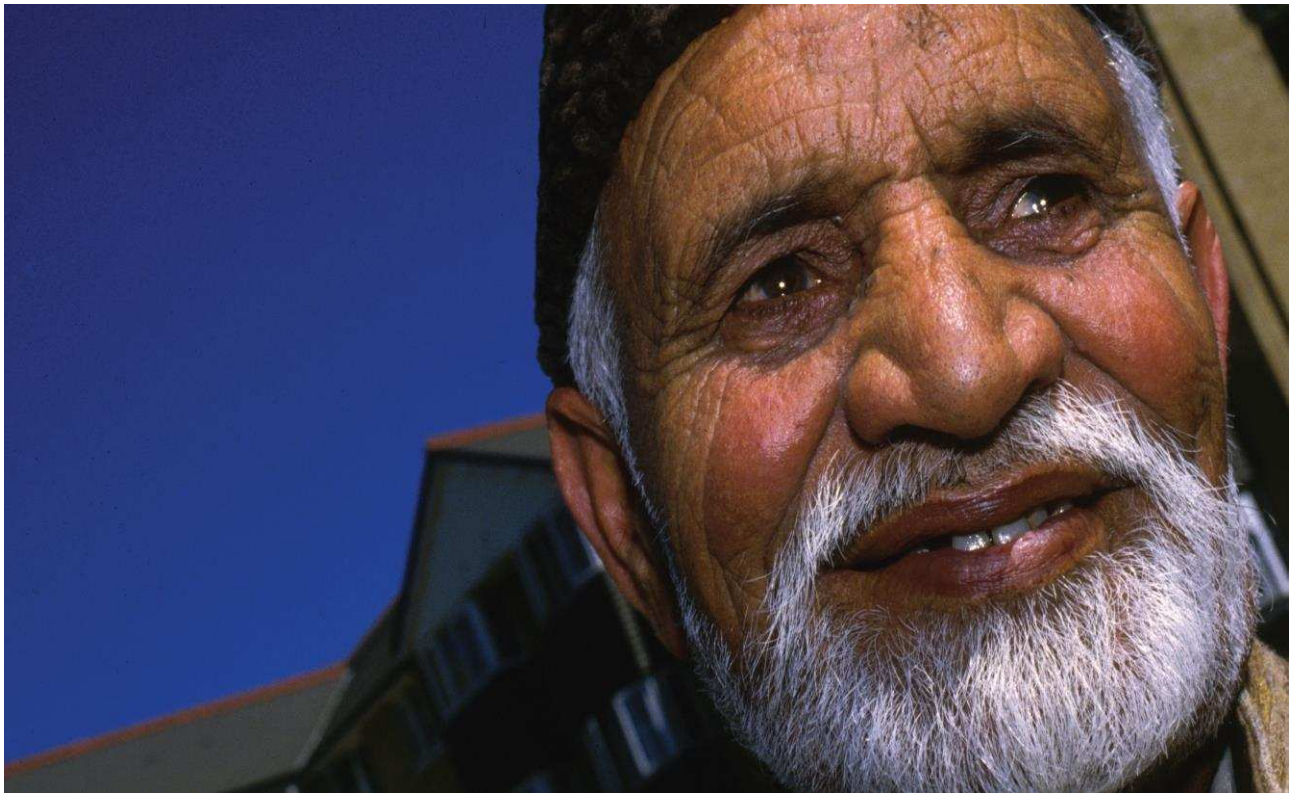
Cllr Chris Mote	Elected Councillor, Harrow Council
Coral McGookin	Harrow Local Safeguarding Children's Board (LSCB)
DCI Peter Stride	Metropolitan Police – Harrow
Avani Modasia	Age UK Harrow
Deven Pillay	Harrow Mencap
Visva Sathasivam	Adult Social Care, Harrow Council
In attendance	
Ash Verma	Healthwatch Harrow
Officers supporting the work of the LSAB	
Sue Spurlock	Manager Safeguarding Adults and DoLS Services – Harrow Council
Seamus Doherty	Safeguarding Adults Co-ordinator - Harrow Council

Appendix 6

Harrow LSAB Attendance Record 2014/2015

Organisation	15/9/14	27/6/14	8/12/14	18/3/15	Total meetings attended
Brent and Harrow Trading Standards	x	x	X	X	0
Harrow Council - Housing Department	✓	x	X	✓	2
London Ambulance Service	x	x	X	X	0
London Fire Service	✓	✓	✓	X	3
Carer Support – Harrow	x	x	X	X	0
Harrow Council - Adult Social Services	✓	✓	✓	✓	4
Harrow Council - elected portfolio holder	✓	✓	✓	✓	4
Harrow Council - shadow portfolio holder	✓	x	X	✓	2
Mind in Harrow	✓	✓	✓	✓	4
NHS Harrow (Harrow CCG)	✓	x	✓	X	2
Ealing Hospitals Trust (Harrow Provider Organisation)	✓	✓	✓	X	3
North West London Hospitals Trust	✓	✓	✓	✓	4

Harrow CCG – clinician	✓	X	X	X	1
Local Safeguarding Children Board (LSCB)	x	✓	X	✓	2
Royal National Orthopaedic Hospital	✓	✓	X	✓	3
Metropolitan Police – Harrow	✓	X	✓	✓	3
Age UK Harrow	✓	✓	X	X	2
Harrow Mencap	✓	✓	✓	✓	4
CNWL	✓	✓	✓	✓	4
Harrow Association of Disabled People	x	✓	X	X	1
Private sector provider representative (elected June 2013)	x	✓	✓	✓	3
Public Health	x	✓	✓	X	1
Department of Work and Pensions	x	✓	x	X	1
In attendance					
Care Quality Commission (CQC)	x	x	x	X	0
Healthwatch Harrow	x	x	x	x	0
Safeguarding Adults Service – to support the Board	✓	✓	✓	✓	4



SECTION 7 - FURTHER INFORMATION & CONTACT DETAILS

Further information/contact details

For further information about this report or any aspect of safeguarding vulnerable adults at risk of harm in Harrow, the website is:

www.harrow.gov.uk/safeguardingadults

If you would like information or advice (including how to access the multi-agency training programme) the Safeguarding Adults Service can be contacted on the telephone number below or via e-mail at:

safeguarding.adults@harrow.gov.uk

If you are concerned about an adult that might be at risk of harm and want to make a referral, this can be done through Access Harrow on: 020 8901 2680 (e-mail: ahadultsservices@harrow.gov.uk)

Any enquiries about the Deprivation of Liberty Safeguards (DoLS) including requests for authorisations can be e-mailed to:

DOLS@harrow.gov.uk

DoLS requests can also be sent to the safe haven fax: 020 8416 8269.

The address for written correspondence (to either Access Harrow or the Safeguarding Adults and DoLS Service) is:

Civic Centre
PO Box 7,
Station Road,
Harrow, Middx. HA1 2UH

REPORT FOR: **Harrow Health and Well Being Board**

Date of Meeting:	5 November 2015
Subject:	**INFORMATION REPORT –** Annual Report of the Director of Public Health 2015
Responsible Officer:	Dr Andrew Howe, Director of Public Health
Exempt:	No
Wards affected:	All
Enclosures:	Building Bridges: Reducing Social Isolation and Loneliness: The Annual Report of the Director of Public Health 2015

Section 1 – Summary

This report compliments the Like Minded work on mental health services that is taking place across North West London. It focuses on social isolation and loneliness and the steps that can be taken to improve wellbeing.

FOR INFORMATION

Section 2 – Report

Each year, the Director of Public Health must publish an independent report on health in the borough. The annual report is the Director of Public Health's professional statement about the health of local communities, based on sound epidemiological evidence, and interpreted objectively. The report should be publicly accessible.

The annual report is an important vehicle by which Directors of Public Health can identify key issues, flag up problems, report progress and, thereby, serve their local populations. It will also be a key resource to inform local inter-agency action.

Director of Public Health annual reports should:

- Contribute to improving the health and well-being of local populations
- Reduce health inequalities
- Promote action for better health, through measuring progress towards health targets
- Assist with the planning and monitoring of local programmes and services that impact on health over time

The 2015 report takes as a focus mental wellbeing and the impacts that social isolation and loneliness has on people's wellbeing. The second half of the report focuses on what people can do for themselves and how they can help others to improve mental wellbeing using the five key messages: Connect, Be Active; Keep Learning,; Take Notice and Give. It illustrates actions that are already happening in the borough on each of these issues.

The report does not have specific recommendations but highlights some of the broad actions that are needed to continue to address the issues across the heath and local government sectors. These actions will be addressed in the associated public health work streams and others are encouraged to take these into consideration in their commissioning plans.

Section 3 – Further Information

Legal Implications/Comments

Under Section 73B(5) of the National Health Service Act 2006 The director of public health for a local authority must prepare an annual report on the health of the people in the area of the local authority.

Section 4 – Financial Implications

Whilst this report does not have any specific recommendations with financial implications, it highlights areas of potential spend that may be necessary to address the issue of mental wellbeing and reducing isolation. Such expenditure is expected to be contained within the ring-fenced public health grant and reflected in future commissioning intentions as appropriate.

Section 5 - Equalities implications

Was an Equality Impact Assessment carried out? No

The 2010 Equality Act outlines the provisions of the Public Sector Equalities Duty which requires Public Bodies to have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- advance equality of opportunity between people from different groups
- foster good relations between people from different groups

The broad purpose of this duty is to integrate considerations of equality into day business and keep them under review in decision making, the design of policies and the delivery of services

The report considers the health inequalities of social isolation and loneliness and the implications for mental wellbeing and identifies certain groups that are most likely to be impacted.

Section 6 – Corporate Priorities

The Council's vision: **Working Together to Make a Difference for Harrow**

The Annual Public Health report will contribute to Harrow's vision in the following points:

- **Making a difference for the vulnerable**
- **Making a difference for communities**
- **Making a difference for families** Statutory Officer Clearance

Name: Donna Edwards	✓	on behalf of the* Chief Financial Officer
Date: 14 October 2015		

Name: Caroline Eccles	✓	on behalf of the* Monitoring Officer
Date: 14.10.15		

Section 7 - Contact Details and Background Papers

Contact: Carole Furlong, Consultant in Public Health, ext 5508

Background Papers: None

Building Bridges

Reducing social isolation and loneliness

The Annual Report of the Director of Public Health 2015

"People are lonely because they **build** walls instead of **bridges.**"

Joseph Fort Newton

Project team

Project Lead and Editor

Leah de Souza-Thomas

Senior Knowledge and Intelligence Analyst

Contributions

Carole Furlong

Consultant in Public Health

Helen Munro Wild

Public Health Analyst

Acknowledgements

Anna Brennan-Craddock

Health Education Partnership

Tim Hoyle

Health Improvement Officer

Ferhat Cinar

Health Improvement Officer

Contents

Foreword

Welcome to this my third Annual Public Health Report as Director of Public Health for Harrow Council.

In my previous reports, I have focused on physical activity and on a series of physical health issues that have remained a challenge over the past 50 years. Loneliness and social isolation have been shown harmful to our health: lacking social connections has a similar impact on our risk of dying early as smoking 15 cigarettes a day, and is even worse for us than obesity and physical inactivity. So this year, I have chosen to look at the issues of loneliness, social isolation and how it affects both our mental and physical wellbeing.

I'm sure that many of us have felt a transitory loneliness when we are away from a loved one or a best friend or if we feel excluded from a group. This feeling of loneliness can occur as a short term thing caused by feeling alone on occasions like Christmas or holidays when others are with friends and family but it can be a chronic problem, whereby people feel lonely all of the time. It is linked to social isolation but they are by no means the same thing.

Across North West London, health services, councils and the voluntary sector are working on a programme called Like Minded which aims to support people to improve their personal mental wellbeing and to make sure that where people need help, it is there for them.

In this report, I have looked at what loneliness and social isolation are; how they affect our health; how we can be more aware of the issues when we commission services; how everyone can help reduce loneliness and how people can help themselves. This fits into the Like Minded programme in a number of ways: by promoting awareness of mental wellbeing; by promoting resilience and prevention of mental health needs; by highlighting the relationship between physical and mental health; and how we all have a part to play in helping ourselves, our family and friends and our society in general.

In naming this report, we asked for ideas from the public health staff and I think the name we've come up with "Building Bridges" is a positive, forward thinking title. It makes me think of moving forward and connecting. I hope that this report makes you look at what you can do, whether big or small, to reduce loneliness in our society and therefore take a step towards better wellbeing.

Dr Andrew Howe

Direct of Public Health

Harrow Council

Key Messages

- Good mental health and wellbeing is about feeling good and functioning well. It is a resource that allows individuals to live a long, productive life. It is good for individuals, families, business and the public purse.

- Social isolation and loneliness have a considerable bearing on the lives of people in Harrow regardless of age. There is evidence to suggest that of the two experiences social isolation is more deadly that loneliness.

- The amount and quality of social connections with people around us are vitally important to an individual's wellbeing. On average people in the UK report have a good family life and more than half (55%) of adults over the age of 16 reported that friendships and associations within their communities meant a lot to them.

- In addition, to having good mental health services it is important that individuals are aware that there are things that they can do for themselves to improve their own and other's mental health and wellbeing.

- The New Economics Foundation (NEF) have produced the 5 ways to wellbeing; a set of evidence-based actions which promote people's wellbeing. These actions are simple things that individuals can do in their everyday lives to improve mental wellbeing.

- We have used these five actions to get adults and children to start thinking about how they can ameliorate the social isolation and loneliness felt in the borough.

Mental Wellbeing

What is it & why is it important?

The concept of wellbeing involves both the mind and the body and so when we talk about mental wellbeing; we're talking about more than just happiness. That isn't to say that, feeling happy isn't part of mental wellbeing it is, nevertheless, far from the all of it.

There is a more profound type of wellbeing, one which is about living in a way that is good for you and of benefit for others around you. Feelings of gratification, pleasure, self-assurance, a sense of worth and involvement with the world are all a part of mental wellbeing. Added to this is the feeling that you can do things you want to do and have healthy relationships, which bring joy to you and those around you. Unsurprisingly, good mental wellbeing does not mean that you have these feelings all of the time, but that crucially you have the resilience and tenacity to cope when times are tougher than usual.

And so, mental wellbeing can be concisely summed up as feeling good and functioning well. From this definition it's clear to see why it is important. Good mental wellbeing is a resource that allows people to live long productive and fruitful lives by realising their full potential, fulfilling their needs, making meaningful contributions to society and coping with the stresses of life. It enables social, economic and personal development fundamental to individual wellbeing, with benefits for both society and the individual.

Good mental wellbeing is good for business; employees with good mental wellbeing are generally more productive, perform better, are more likely to consistently attend work and have fewer workplace accidents. The elimination of the causes of lost productivity, workplace accidents and absenteeism increase company efficiency, productive capacity and by extension the quality of goods produced or services delivered.

Good mental wellbeing is also good for family life. The

Wellbeing and Public health

Wellbeing is a meaningful, positive outcome for individuals and many sections of society; it tells us how well people perceive that their lives to be.

Adequate living conditions (e.g. good housing and fair employment) are fundamental to wellbeing. Measuring these conditions is an important aspect of public policy. However, these types of indicators fail to measure what is really important - what people think and feel about their lives, the quality of their relationships, their positive emotions and resilience, levels of interaction with their communities, the realisation of their potential, or their overall satisfaction with life.

A better appreciation of wellbeing could be achieved through the use of indicators such as these and would enable a more holistic approach to disease prevention and health promotion.

Good wellbeing has been found to be associated with healthy behaviours, mental and physical wellness, social connectedness, better self-perceived health, longevity and productivity.

quality of family relationships throughout childhood, and more specifically negative parenting, have been found to predict a range of common psychiatric disorders in adult life[1], perpetuating the cycle or exacerbating poor lifestyle choice and encouraging deviance. Conversely, children of parents with good mental wellbeing are more likely to grow up in secure, supportive, loving households. Secure children show less aggression and more co-operation in their interaction with peers[2] and more appropriate, flexible emotional attunement and behavioural responses to a range of social and environmental cues[3,4].

But it doesn't stop there; good mental wellbeing is also good for the public purse. A number of studies have shown that when people receive appropriate mental health care, their use of medical services decline. For example, a study of people with anxiety disorders found that after psychological treatment, the number of medical visits decreased by 90%, laboratory costs decreased by 50%, and overall treatment costs dropped by 35% [5]. Further, researchers have projected that between 50% and 70% of a doctor's normal caseload consists of patients whose medical conditions are significantly related to psychological factors[6]. Individuals with untreated mental health problems are more frequent attendees to the doctor's surgery, with visits occurring twice as often as people who receive mental health care[7]. This is because chronic stress and anxiety can contribute to physical problems such as heart disease, ulcers and colitis, reduce the strength of the immune system and increase vulnerability to conditions ranging from the common cold to cancer. Psychological problems also increases the propensity to make poor behavioural choices, such as smoking, excessive alcohol consumption and drug misuse which can contribute to physical ill health and increased medical and criminal justice costs.

The health & wellbeing strategy

Harrow's refreshed Health & Wellbeing strategy for 2016 refocuses collaborative efforts for the next five years on helping residents to start, live, work and age well. It highlights the uneven distribution of health in Harrow and sets out the need to improve mental and physical health for all, with concerted effort for communities with the greatest need.

The Health and Wellbeing board members have committed to work together and use every opportunity to promote mental wellbeing throughout life. This means co-comissioning integrated and well coordinated health and care for all but also supporting communities to find new ways to help each other especially those with the greatest risk of poor mental and physical health. The board aims to reduce inequality in life expectancy and healthy life expectancy in Harrow and improve mental health in Harrow.

The strategy has been informed by an engagement event held in Harrow on the 16th July 2015. The visual minutes from the event are shown below (figure 1 and 2). The event highlighted a range of issues and opinions held by residents. One of the issues raised during the session was the sense of increasing loneliness and social isolation in the borough.

Across North West London a new strategy is being developed to improve mental health and wellbeing. Harrow council we have linked in with this strategy called Like Minded, it is being

developed by the NHS and its partners, with the aim of establishing excellent, integrated mental health services to improve mental and physical health.

The goal of strategy is to promote wellbeing and to improve the mental health care and support we receive if we need it. One of the eight issues outlined by Like Minded is that not enough people know how to keep mentally well; the strategies ambition is to improve wellbeing and resilience, and prevent mental health needs where possible by:

- Supporting people in the workplace
- Giving children and young people the skills to cope with different situations and
- Reducing loneliness for older people.

Ultimately, we want to help residents to improve their personal mental wellbeing, to know how to look after themselves and to keep well.

FIGURE 1 VISUAL MINUTES FROM HEALTH AND WELLBEING ENGAGEMENT EVENT 16 JULY 2015 (PART A)

FIGURE 2 VISUAL MINUTES FROM HEALTH AND WELLBEING ENGAGEMENT EVENT 16 JULY 2015 (PART B)

Social isolation and loneliness

Social isolation is characterised by an absence of social interactions, engagement and social support structures within the wider community or society. When viewed in terms of voluntary action e.g. a religious retreat, isolation can be seen as a positive action which supports mental wellbeing and resilience but more ordinarily it is involuntary, created or imposed through marginalisation or discrimination by families or communities or through deteriorating mental or physical capacity. This type of isolation is associated with negative mental and physical health outcomes. Social isolation can develop over short periods of time linked to a trigger event or disease, or be protracted and pervasive.

As an independent risk factor, loneliness has been associated with lower reported life satisfaction, alcoholism, suicide and physical illness. Social isolation has wide ranging impacts extending from premature mortality to excessive morbidity, with animal studies demonstrating the physiological impacts on neurological development and function, cardiovascular function and wound healing. Animal studies, have found that social isolation in adolescence has long term impacts into adulthood, with an association with addictive patterns[8]. The negative impact on the health and wellbeing of older people from social isolation and loneliness, increases the risk of death in a similar way to well known risk factors such as smoking or coronary heart disease[9,10]. It is thought this occurs because there are delays in seeking medical attention leading to earlier death, in part because being isolated may imply that no one else is aware of the first signs of illness, or worsening symptoms of disease.

Social isolation and loneliness

Social isolation describes an absence of social interactions, social support structures and engagement with wider community activities.

Loneliness describes an individual's personal, subjective sense of lacking connection and contact with social interactions to the extent that they are wanted or needed.

Social inaction describes a state where individuals choose or are unable to take part in social actions and are therefore disconnected from concepts of 'we-ness' and civic society.

Social isolation and loneliness are not mutually exclusive and the various features of loneliness make it entirely feasible to be lonely but not socially isolated.

Critically, however, social contact can have intense physiological effects; affectionate physical contact is linked to lower levels of the stress hormone cortisol and inflammation.[11].

Loneliness and isolation tend to go hand in hand, however according to a growing body of research there is a difference. So which exerts more of an impact – the emotional toll of feeling alone or the lack of physical and social contact? A recent study assessed the extent to which the association between social isolation and mortality is mediated by loneliness. The authors found that mortality was higher among more socially isolated and lonelier participants. However, after adjusting for demographic factors and health at the start of the study, social isolation remained significantly associated with mortality while loneliness did not. These findings suggest that while both isolation and loneliness impair quality of life and wellbeing perhaps efforts to reduce isolation are likely to be more relevant to mortality and as such physically engaging people with those who are socially isolated may do more for improving their health and survival than trying to superficially address the feelings of being left out or lonely[11].

Who is affected

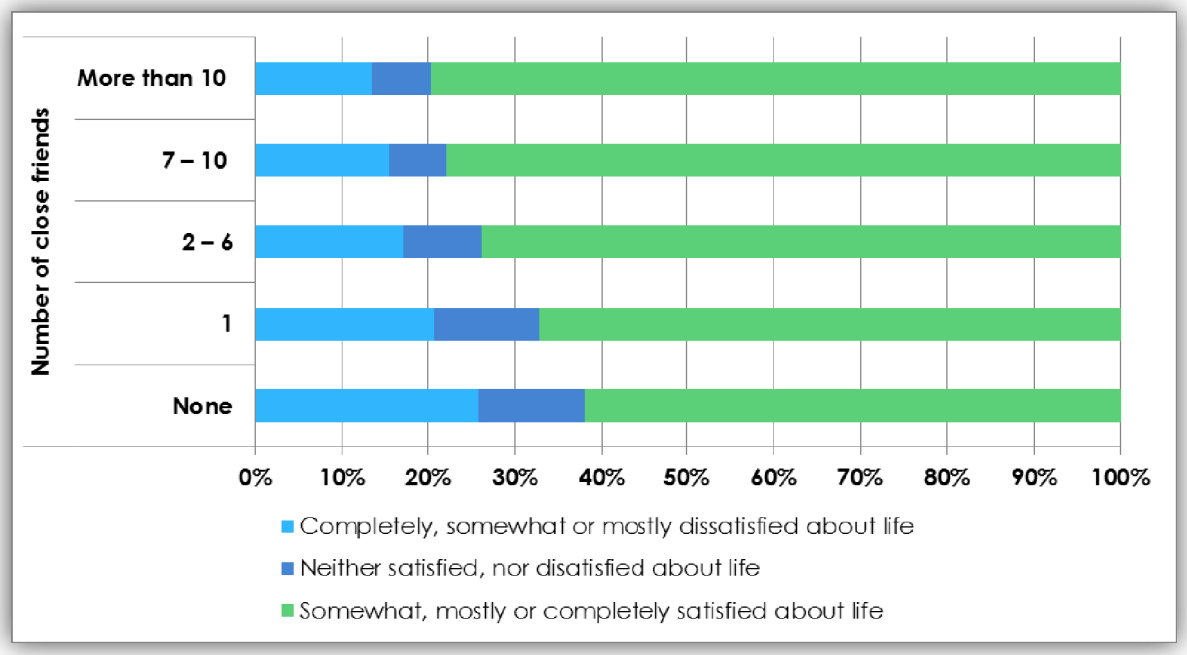
A number of life events can contribute to feelings of isolation and loneliness, these range from the obvious such as bereavement where many can find it difficult to spend time with others following the loss of a loved one, work transitions such as restructuring, redundancy and retirement which can lead to many becoming more isolated as they adjust to changes in responsibilities, identities and a new routine to the less obvious such as parenting which while generally positive can leave many new parents feeling quite isolated. Also, the location and manner in which we live can be perceived by the individual to be quite intimidating and unsafe resulting in feelings of loneliness and isolation. Additionally, physical limitations, poor mobility and transport issues can cut people off from access to the rest of the community, financial pressures may make people feel that they cannot afford to get out or to take part in activities that they may have previously enjoyed and social anxiety, feelings of nervousness or dread in relation to unfamiliar social settings, can all make people withdraw for social connectedness.

Research shows that loneliness is widely prevalent throughout society among people in marriages or relationships, and among those who have families and successful careers[12]. Older adults are particularly vulnerable to social isolation and loneliness due to the loss of friends and family, mobility or income. But it's not just older people; all vulnerable groups are susceptible to social isolation and loneliness including young care-leavers, refugees and those with mental health problems. Longitudinal studies have found that older people who were part of a social group intervention had a greater chance of survival than those who had not received such a service. Loneliness has been described as a social pain – a psychological mechanism meant to alert an individual to feelings of isolation motivating them to seek social connectedness[13].

In 2011/12, around one in ten people (11%) in the UK reported feeling lonely all, most or more than half of the time with just over a third of people in the UK reporting that they wish they could spend more time with their family (36%) and have more social contacts (36%)[14].

The relationships an individual has with relatives and friends (described as 'strong ties' or 'bonding ties'), work colleagues or neighbours (described as 'weak ties' or bridging ties') are all important for personal wellbeing. One important aspect of personal relationships is the size of people's networks such as the number of close friends. Most people (95%) reported having at least one close friend, with a majority (68%) having between two and six close friends. The proportion of people reporting being dissatisfied with their life increases as the number of close friends decreases. A quarter (26%) of people with no close friends reported being mostly, somewhat or completely dissatisfied about their life compared to 21% of those having one close friend, 17% of those having between two and six close friends and 14% of those having more than 10 close friends (figure 3)[14].

FIGURE 3 OVERALL LIFE SATISFACTION BY NUMBER OF CLOSE FRIENDS, 2011/12



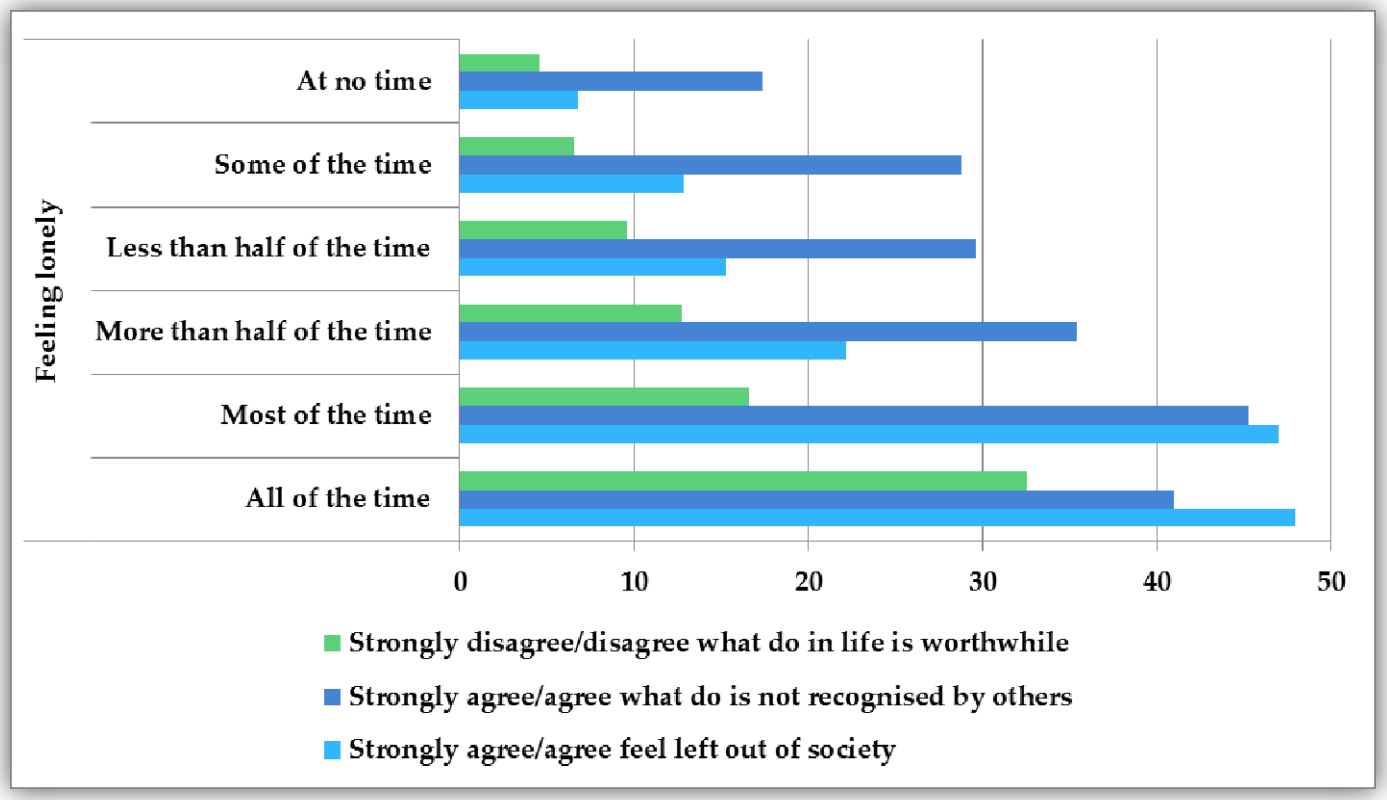
Data source: Office for National Statistics

The frequency of contact with others has been highlighted as an important indicator of people's wellbeing. The large majority of people reported being in touch (by visiting, telephoning or any other mode of contact) with their closest friend very regularly, either on most days (34%), or at least once a week (38%). According to the European Social Survey 2012/13, 63% of people met socially with friends, relatives or colleagues at least once a week, but 13% of people did so less than once a month or never. The main reasons for not going out socially or visiting friends were: the lack of time (as mentioned by 31% of those who did not go out socially), a

health condition, illness, impairment or disability (26%), financial reasons (19%) and caring responsibilities (18%), or no one to go with (9%).

Around one in ten people (11%) reported feeling lonely all, most, or more than half of the time. There was a strong relationship between loneliness and other negative experiences, such as feeling left out of society, feeling that things done in life are not worthwhile and feeling a lack of recognition by others (figure 2). Among those reporting feeling lonely all the time, nearly half (48%) also reported feeling left out of society, while four in ten (41%) reported feeling that what they do is not recognised by others and three in ten (32%) feeling things they do in their life are not worthwhile. In comparison, among those reporting never feeling lonely, 7% reported feeling left out of society, 17% feeling that what they do is not recognised by others and 5% feeling that what they do in their life is not worthwhile.

FIGURE 4 PEOPLE'S NEGATIVE PERSONAL WELLBEING BY FEELING OF LONELINESS, 2011/12



Data source: Office for National Statistics

Social Networking

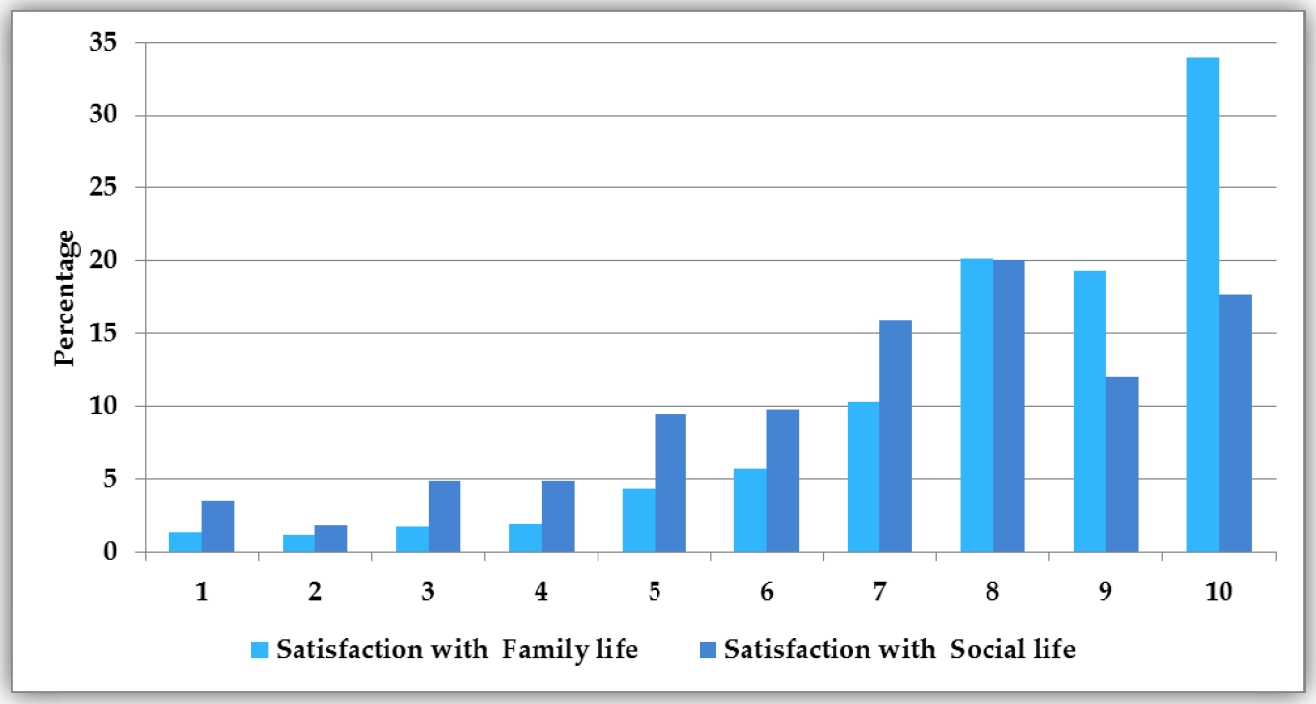
Belonging to a social network website could build social capital, by maintaining links with family and friends and widening existing social networks. Half of people (46%) reported belonging to

a social website. Among those who belonged to a social website, half of people (53%) spent less than an hour per day on week days interacting with friends through social websites while a quarter (24%) spent between one and three hours per day interacting with friends through social websites on week days.

Quality of relationships

Subjective measures of satisfaction often reflect the quality of relationships an individual has with family and friends. Satisfaction with both family life and social life has been shown to have a positive correlation with life satisfaction and happiness. The average ratings for satisfaction with family life and social life were 8.2 and 7.1, respectively, out of 10. Figure 5 shows the distribution of ratings for satisfaction with family life and with social life. A higher proportion of people (53%) reported very high satisfaction with family life as (rating of nine or ten out of ten), compared to their satisfaction with social life (30%). A higher proportion of people (15%) rated their satisfaction with their social life as low (rating of one to four out of ten), compared to their satisfaction with family life (6%).

FIGURE 5 DISTRIBUTION OF SATISFACTION WITH FAMILY LIFE AND SATISFACTION WITH SOCIAL LIFE RATINGS, 2011/12



Data source: Office for National Statistics

NB: 1 = very dissatisfied & 10=very satisfied

Talking to neighbours Around two out of three people (66%) reported that they regularly stop and talk with people in their neighbourhood. A large proportion (85%) of those for whom having a local friend is important, reported stopping and talking regularly with people in their neighbourhood. In comparison, only 24% of those for whom having local friends is not important reported stopping and talking regularly with people in their neighbourhood. It has been highlighted before that for people to form interconnected social networks in their local area, residential stability is very important[5].

Changing society

For centuries in the United Kingdom, we have seen increases in life expectancy and better public health; we now have clean water, fewer mothers die during childbirth and largely as a result of becoming a wealthier nation there have been major improvements in treatment and diagnosis. But focusing solely on wealth as a measure of progress may not be all it's cracked up to be. The sense of togetherness so fondly recalled by those who lived through the second world war has long since dissipated leaving behind growing inequality, greater competition for a piece of the pie and fear propagated by divisive rhetoric. It is no wonder that evidence from population surveys in which people were asked to rate their own happiness or mental wellbeing, have found that mental wellbeing has not improved.

Buying into the division robs us of our empathy, logic and humanity and is guaranteed to leave us depressed and despondent. Our desire for acquiring more - more money and more luxury goods – cultivated by advertisers who play on making us dissatisfied with what we have and encourage invidious social comparison ensuring that we spend more time striving for material wealth and possession and less time focussed on the things that truly matter for our family life, relationships and quality of life. This prevents us from thriving and flourishing at an individual and societal level.

It's time to rethink mental wellbeing.

What can be done

A key focus for the council is to allow older people to remain in their own homes and communities, rather than living in residential care. It fosters independence and offers a higher quality of life. It is also more cost effective and given the current programme of austerity across all government departments this is important. Social isolation and loneliness, however, is a risk to independent living.

We know that the actions we take and the way we think have the biggest impact on mental wellbeing and as such improvements can be achieved by these actions. From a board evidence base, the New Economics Foundation (NEF), reduced a long list of actions to a set of five key messages; connect, be active, keep learning, take notice and give. The Children's Society have for children replaced 'give' with 'be creative and play'. These actions are designed to promote their own positive feedback loops in order to reinforce similar and more

frequent wellbeing promoting behaviours. Following the advice of these interventions enhances personal wellbeing by increasing positive feelings and bolstering mental capital.

The following is a borough specific guide to how the five ways to wellbeing can be used to help reduce social isolation and feelings of loneliness. If you approach these actions, with an open mind, you can judge the results yourself.

Connect

Connect with people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day

Why is it important?

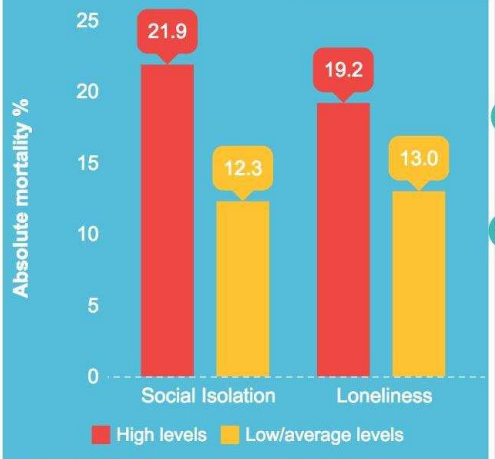
1 PROMOTING WELLBEING:
Social relationships are critical for promoting wellbeing and for acting as a buffer against mental ill health. This seems to be the case for people across all ages of society.

2 PREVENTING COMMON MENTAL DISORDERS (CMDs):
A primary social network (total number of close relatives and friends) of three or less predicts the probability of CMD in the future even when previous CMDs have been adjusted for.

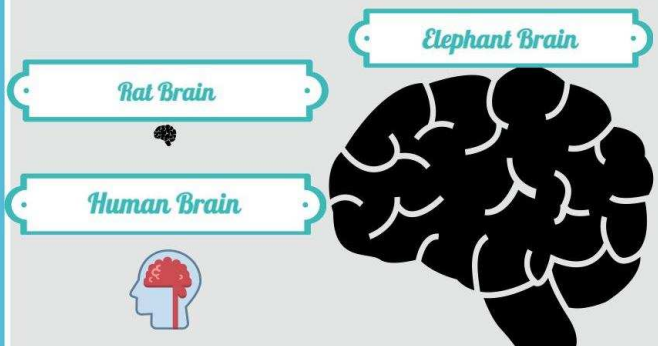
3 IMPROVES LIFE SATISFACTION:
Life goals associated with a commitment to family, friends, social and political involvement promoted life satisfaction. While, life goals associated with career success and material gains were detrimental to life satisfaction.

CONCLUSION: Giving time and space to both strengthening and broadening social networks is important for wellbeing

Humans are social creatures



Social isolation is repeatedly shown to prospectively predict mortality and serious morbidity both in general population samples and in individuals with established mortality.



Brain size in the animal kingdom generally correlates to body size. An elephant's brain is huge (4783g), a rat's is tiny (2g), the adult human brain (1400g) is the exception. Brain size is the strongest predictor of an animal's social size. We have big brains, relative to our size, in order to socialise.

What can I do?

Tip 1:
Slow down and take time to spend with family, friends and loved ones, share meal times, pursue activities that you can enjoy, listen & support each other

TRY THIS OUT!

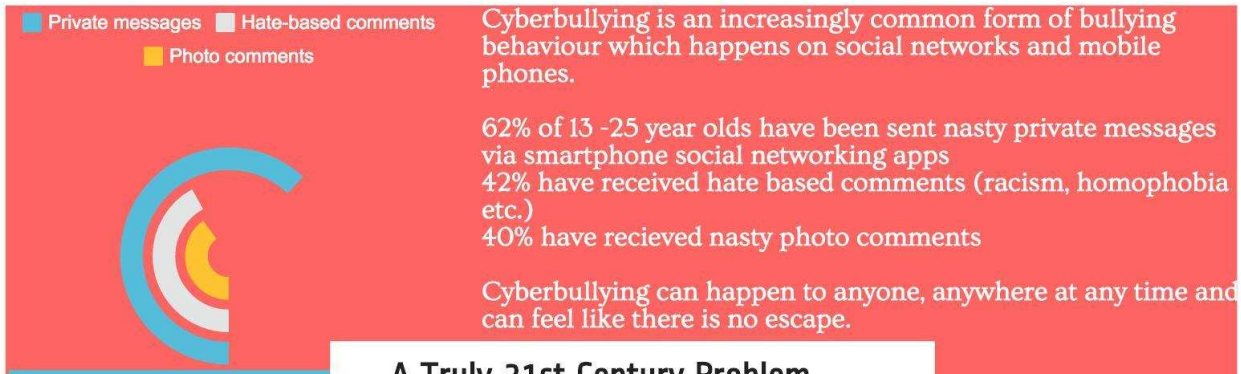
Tip 2:
Keep in touch with friends & family, the internet can be very useful in maintaining long distance relationships

Connecting with others, even on the most basic of levels could improve your wellbeing

Tip 3:
There is much greater neural activity during face to face conversation suggesting that this is an important mode of communication

Tip 4:
Making new friends can help you lead a more fulfilled enlightened life

Tip 5:
Ask for help, don't struggle alone. Offer help to others too



Cyberbullying is an increasingly common form of bullying behaviour which happens on social networks and mobile phones.

62% of 13 -25 year olds have been sent nasty private messages via smartphone social networking apps
42% have received hate based comments (racism, homophobia etc.)
40% have recieved nasty photo comments

Cyberbullying can happen to anyone, anywhere at any time and can feel like there is no escape.

A Truly 21st Century Problem

49% of 13-25 year olds experienced a loss in confidence as a result of bullying

Social networking has it's place it is often viewed as a useful tool in connecting with family and friends who live further afield.

There are negative impacts, social networking may make you more susceptible to peer pressure, can destroy your ability to think independently and may damage your self esteem.

5% of 13 year olds send naked photos several times a week

49% turned to self harm as a coping mechanism

22% tried to to change their appearance to avoid further abuse

24% of 13 - 25 year olds have had a naked photo shared without their consent

16% of 13 - 25 year olds said sexting was normal

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What support is available?

Harrow's Happiness Campaign

Harrow's Happiness campaign was inspired by the Action for Happiness Movement. The founders have taken the movement's pledge to bring more happiness to the world and they are starting where they know best - Harrow.

Every month they perform a number of activities designed to bring happiness to the people they encounter in the borough. These include:

*Hugs4Harrow - free hugs flash mob takes to the streets somewhere in Harrow.

*HIGH5Fridays - giving HIGH 5s to people while saying "well done for getting through the week', 'you're all doing great", "thanks for working so hard this week", "have a great weekend" and "keep smiling"...

*Street Smilers - hang around busy places with a sign and smile at people

*#HappyChalk - leave happy chalk messages of encouragement and peace on the streets of the borough

*Happy Snappers Photography Walks - local people lead walks in different parts of Harrow to take photos of happy people and places

*Operation #HappyOnTheBeat - encouraging people to smile and say hello to officers of Harrow Metropolitan Police

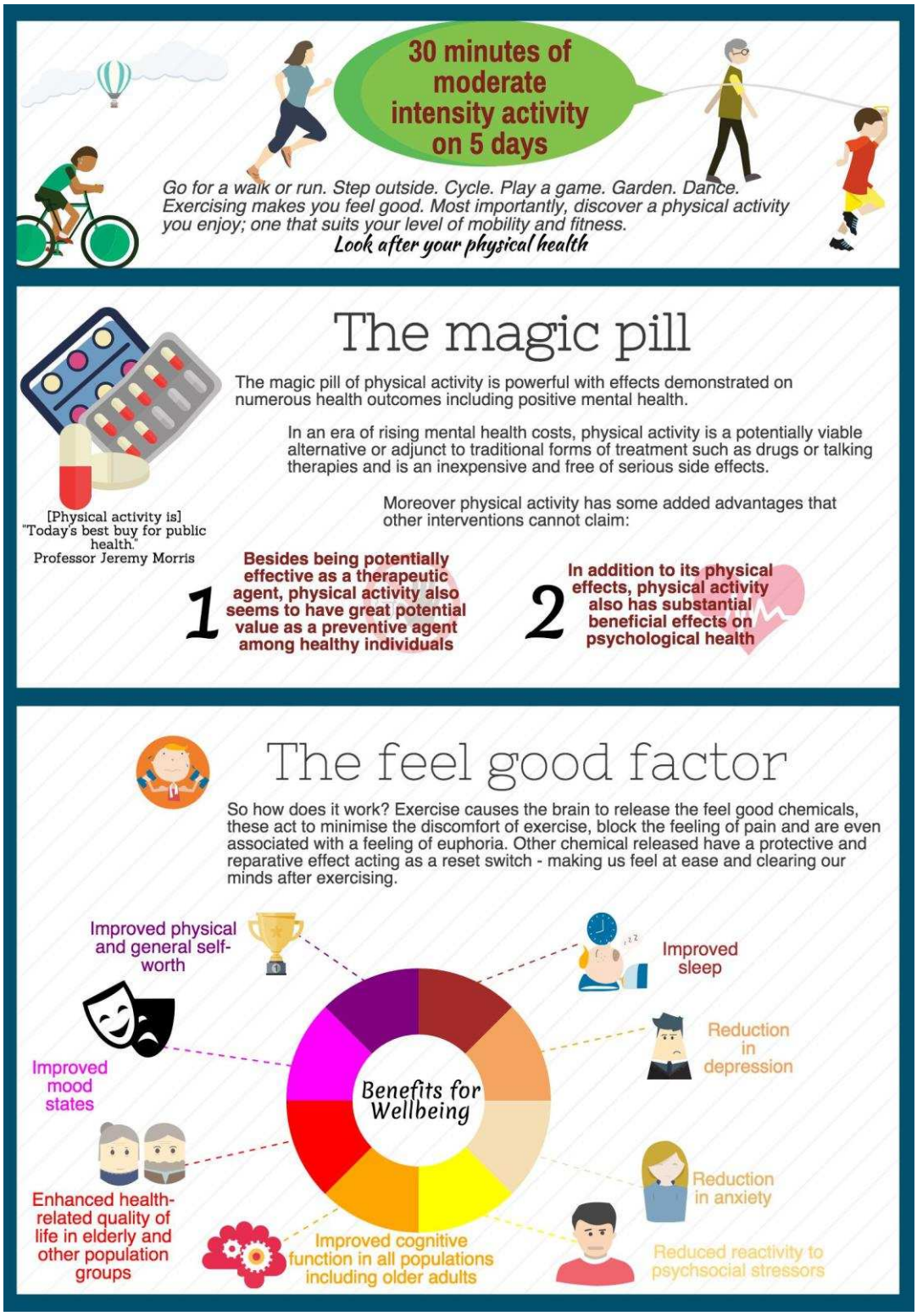
* Happy hour on www.radioharrow.org. Send your good news, stories and acts of kindness, happy requests and tell us the community activities that are making Harrow Happier to the Happiness Campaign show on Harrow Community Radio or be a guest good news reader on the show.

Join Harrow's Happiness campaign, like them on Facebook and follow them on Twitter.

Some of the things that the campaign want to do in the future that they need your help with are:
*Organise street art exhibitions
*Start a laughter club
*Get donations for a thank you postcard stall and a little sit down sofa
*Sing a longs
*Fancy dress days
*Pop up bands and poets
*Comedy group

Stay Connected

Be active


30 minutes of moderate intensity activity on 5 days
Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy; one that suits your level of mobility and fitness.
Look after your physical health
The magic pill
The magic pill of physical activity is powerful with effects demonstrated on numerous health outcomes including positive mental health.
In an era of rising mental health costs, physical activity is a potentially viable alternative or adjunct to traditional forms of treatment such as drugs or talking therapies and is an inexpensive and free of serious side effects.
Moreover physical activity has some added advantages that other interventions cannot claim:
[Physical activity is] "Today's best buy for public health." Professor Jeremy Morris
1 Besides being potentially effective as a therapeutic agent, physical activity also seems to have great potential value as a preventive agent among healthy individuals
2 In addition to its physical effects, physical activity also has substantial beneficial effects on psychological health
The feel good factor
So how does it work? Exercise causes the brain to release the feel good chemicals, these act to minimise the discomfort of exercise, block the feeling of pain and are even associated with a feeling of euphoria. Other chemical released have a protective and reparative effect acting as a reset switch - making us feel at ease and clearing our minds after exercising.
Benefits for Wellbeing
Improved physical and general self-worth
Improved sleep
Improved mood states
Reduction in depression
Enhanced health-related quality of life in elderly and other population groups
Reduction in anxiety
Improved cognitive function in all populations including older adults
Reduced reactivity to psychsocial stressors

Diet

In order to get the most out of exercise you need to eat healthy. Eating a well balanced diet at regular mealtimes with plenty of water and vegetables will help you feel more healthy and happy. Stopping or reducing your alcohol intake, and avoiding tobacco and recreational drugs can also help improve your general wellbeing.

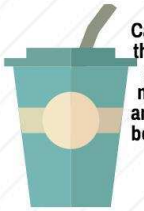
So, what does a well balanced diet look like? The eatwell plate opposite highlights the different types of food that make up our diet, and shows the proportions we should eat them in to have a healthy, balanced diet.

You don't need to do it at every meal. But try and aim to get the balance right every day.

Sleep

Sleep is a much more complex process than many people realise, but it is crucial to the health of us all. The Great British Sleep Survey data indicate the extent to which poor sleep can negatively impact on a person's daily life with inevitable consequences for mental wellbeing and the ability to be active.

Caffeine, alcohol and nicotine are all substances which can impair sleep quality.



Caffeine makes it harder to sleep because it stimulates the central nervous system, increasing your heart rate and adrenaline production, and slowly suppressing melatonin (the hormone that helps control your sleep and wake cycle) production. It takes a long time for the body to break down caffeine, so drinking coffee during the day can affect sleep at night

Alcohol can help people fall asleep but it also impairs sleep quality during the second half of the night and it is a diuretic which means that you may need to wake during the night to go to the toilet, disrupting your sleep pattern.

Nicotine may impair sleep, smokers take longer to enter sleep and have less total sleep time (approximately 14 minutes less per night) compared to those who have never smoked.

Both shift work disorder and jetlag are common expressions of circadian rhythm disorders. Humans are not designed to be awake during the night and asleep during the day.

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Harrow walks

Last year I was diagnosed with cancer following my treatment I suffered from coughs for months, I was in constant pain and my energy levels were rock bottom. I had not been out walking much during my treatment.

This year I joined the Harrow Walking for Health Group, at first I was the slowest person walking in the slow group and I would need to sit down for a rest before the end of the walk followed by bed rest at home. I was given great support and encouragement by the leaders, this enabled me to carry on walking once a week.

After a couple months I had a medical check up and discovered my glucose levels were raised and I needed extra medication. So I dieted and increased my walking with the group to two walks a week. After four months I had lost weight, my glucose and cholesterol levels returned to normal, my pain levels lowered; I felt great and I was able to come off the extra medication.

During the summer, my energy levels increased and I was walking with the group three times a week and comments were made about how well I was walking. In August, I was given the all clear regarding my cancer I am still recovering from my treatment but I have come a very long way.

Joining the Walking for Health Group, has helped me to loose weight and keep my diabetes and weight under control it has also helped me recovering from my cancer treatment by increasing my energy level and enabling me to cope better. On the walks I have met very interesting people and I have enjoyed the social get-together at the end of the walks. All the leaders have been very supportive and I look forward to the walks each week.

A Harrow walker
10th October 2014

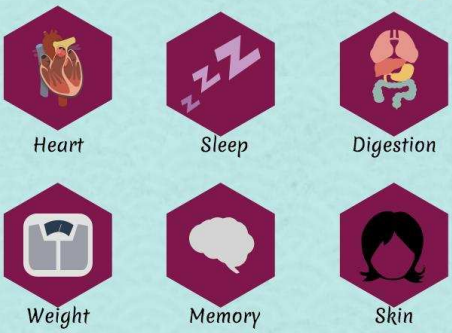
Take notice


Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are on a train, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.
Why bother?
Reminding oneself to 'take notice' is a step in the right direction towards strengthening and broadening awareness on an interpersonal (within person) level.
Studies have shown that being aware of what is taking place in the present directly enhances wellbeing.
Heightened awareness enhances an individual's self-understanding and allows an individual to make choices in alignment with their own values and intrinsic motivations.
Identify mood triggers
Keeping track of your moods in a mood diary can help you work out what affects your mental wellbeing and recognise changes in your mood that would be difficult to spot otherwise. For example, you may notice that a certain type of food or season affects your mood.
Knowing what affects your moods can help you take steps to avoid or change the situations that have a negative impact on you. Even if you don't change the situation, knowing your triggers can help you remember to take extra care of yourself during difficult times.

Stressed? Think Teflon®, not Velcro®

Sometimes stress can be a positive force, motivating you to perform well at your piano exam or job interview. But all too often in today's fast paced societies it's a negative force. If you experience stress over a prolonged period of time, it could become chronic — unless you take action.

Chronic stress can affect your:



Chronic low level stress "gets under the skin" through a number of bodily systems influencing the release of the hormone cortisol, cholesterol levels, blood pressure and inflammation.

In one study, researchers examined the association between "positive affect" — feelings like happiness, joy, contentment and enthusiasm — and the development of coronary heart disease over a decade. They found that for every one-point increase in positive affect on a five-point scale, the rate of heart disease dropped by 22 percent.

Mindfulness

Mindfulness is an integrative, mind-body based approach that helps people change the way they think and feel about their experiences, especially stressful experiences. It involves paying attention to our thoughts and feelings so we become more aware of them, less enmeshed in them, and better able to manage them.

Mindfulness interventions aim to teach us how to accept our thoughts without unhelpfully identifying with them. When people practice Mindfulness, they are encouraged not to aim for a particular result but simply to 'do it and see what happens.'

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Mindkit: Introduction to Mindfulness

Mind in Harrow's Mindkit programme offers free, interactive wellbeing and resilience sessions, including introduction to mindfulness, to groups of young people, aged 14 to 25 in schools, colleges, universities, youth centres and a range of community organisations. Young people learn about evidenced-based approaches and Mindful Living to look after their mental wellbeing and boost their resilience, which can improve their ability to cope with life's challenges, their self-confidence and performance.

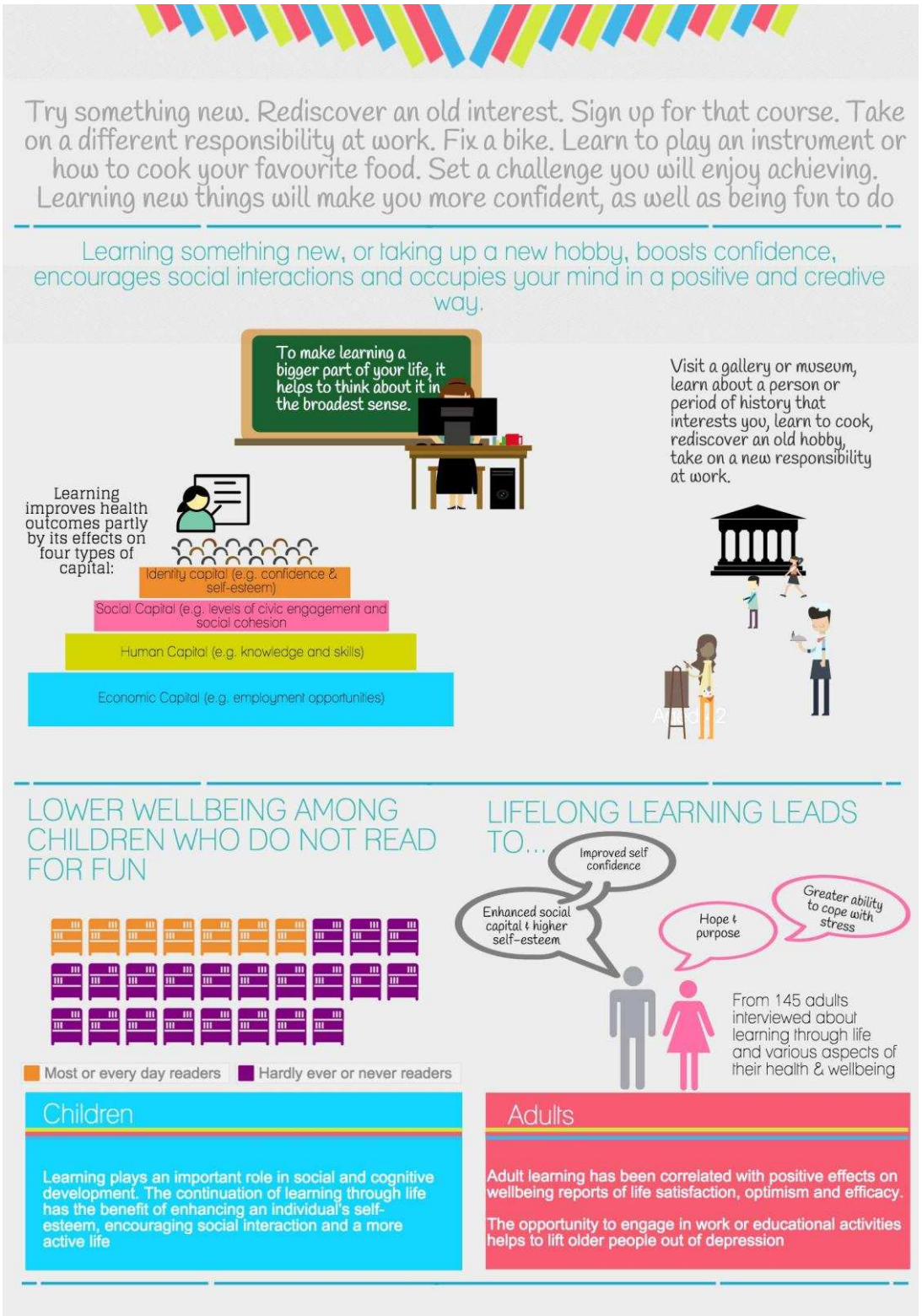
The programme offers session lengths to suit you, a free 40 or 60 minute interactive session, or a 15 minute assembly-style session for larger audiences, that fits in with institutions' and young people's timetables.

Mindkit wellbeing and resilience sessions are delivered by trained, DBS-checked volunteer youth wellbeing trainers who are mainly young themselves (or young at heart!) and speak from their own mental health experiences to inspire others.

Every young person attending a session will receive a printed leaflet with wellbeing tips and a wallet card with information about local services. Online access to information about services and resources is also available. In addition, attendees will get 12 months, free online access to Headspace, a mindfulness meditation tool (usually worth £54.88). Headspace enables young people to practise mindfulness in their own time (Parental or guardian consent is required for young people under 18 to use Headspace).

To book a Mindkit session for your institution, contact Mind in Harrow on 020 8426 0929

Keep learning



Feel the fear and do it anyway!

We often stand in our own way when it comes to trying new things

生き甲斐

In Okinawa (Japan) – a place where people have the longest disability free life expectancy that is they have the best quality of life – ikigai is thought of as "a reason to get up in the morning". The Japanese believe that every one has ikigai and it is the point at which your passion, profession, vocation and mission intersect culminating in your reason for being.
Setting goals that align with your own ikigai are easier to connect with and pursue when fear creeps in, these goals also play an important role in the way learning influences wellbeing.

生き甲斐

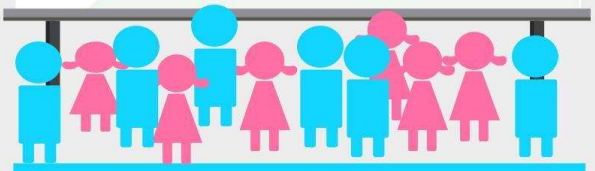
Achieveing your goals will create positive feelings of accomplishment and achievement

What do you think stands between you and where you want to be?

Watch https://www.youtube.com/watch?v=XZRw91uNMq0

Building Resilience

1. Make connections
2. Help others
3. Maintain a daily routine
4. Take a break
5. Teach your child self-care
6. Move towards your goals
7. Nuture a positive self-view
8. Keep things in perspective and maintain a hopeful outlook
9. Look for opportunities for self-discovery
10. Accept that change is part of life



Failure is a matter of perspective

Even successful people fail:

Michael Jordan arguably the one of the greatest basketball players of all time was cut from his high school basketball team because his coach didn't think he was good enough

Warren Buffect one of the world's richest and most successful businessmen, was rejected by Harvard Business School

Richard Branson's academic performance was described as poor

Overcoming failure

Analyse all potential outcomes | Learn to think more positively | Have a contingency plan | Look at the worst-case scenario | Quick wins: Set tiny goals on route to much bigger goals

Children

We tend to idealise childhood, but childhood alone offers no shield against the emotional hurts and traumas many children face.
Building resilience - the ability to adapt to adversity, trauma, tragedy, threats or even significant sources of stress - can help our children manage stress and feelings of anxiety and uncertainty.

Adults

The fear of failure can be immobilising - it can cause us to do nothing and therefore resist moving forward or subconsciously undermine our own progress in an effort to avoid the possibility of a larger failure.
When this happens we're likely to miss some great opportunities along the way.

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Learning in Harrow

Children

Harrow council's public health team fund the Harrow Schools' Wellbeing Programme the programme is available to all primary and secondary schools. The programme is delivered by Health Education Partnership (HEE).

Primary Schools

HER offer consultancy support to meet the requirements of the School Food Plan, staff training to build capacity within schools, develop schemes of work for healthy eating and an online directory of local services.

They also offer transition support by conducting a consultation for Year 6 pupils investigating their hopes and worries about transition which aims to among other things enable pupils to identify what resources and interventions would support them through transition

Secondary Schools

HEE offer the creation of bespoke school action plans and developing emotional wellbeing opportunities for students.

They also work with schools to develop and implement peer mentoring programmes for students to support emotional wellbeing and prevention of risky behaviours.

Transition support comes in the form of gathering the experiences of Year 7 students who have moved to secondary school.

Adults

The Harrow Adult, Community and Family Learning Services is part of the Community and Culture Division of Harrow Council, in the Community Health and Wellbeing Directorate.

It is based at Harrow Arts Centre and provides a wide range of courses across the borough, both directly and through other providers. Currently these providers include: Harrow College, Stanmore College, Mind in Harrow, Royal Mencap Society, African Cultural Association, WEA London Region, Relate London North West, Herts Inclusive Theatre and Anti-racist Alliance Trust.

Learning opportunities include:

English for Speakers of Other Languages (ESOL) in a range of venues

Community-based computer courses in locations that include the Sangat Centre, the Shree Kutch Temple, the Beacon Centre and Kenton Learning Centre

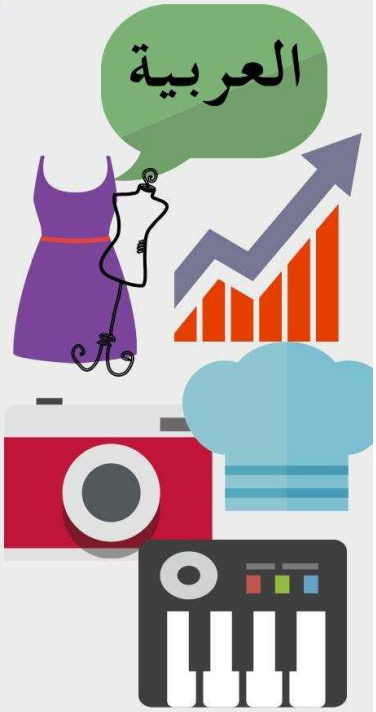
Maths and English Programmes

Family learning courses and activities in schools, childrens centres and community venues

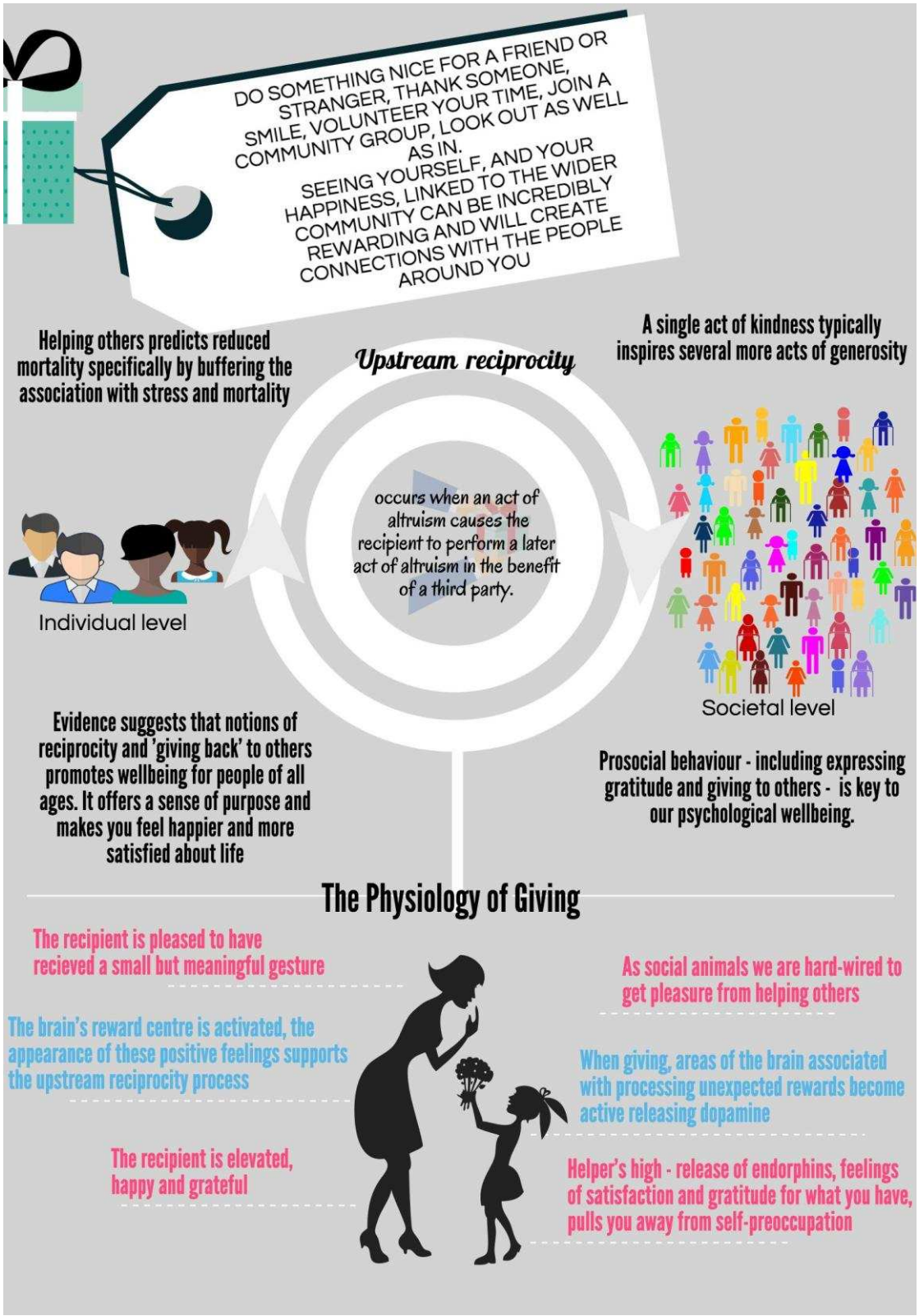
Courses for mental health service users run through the Stepping Stones project of MIND

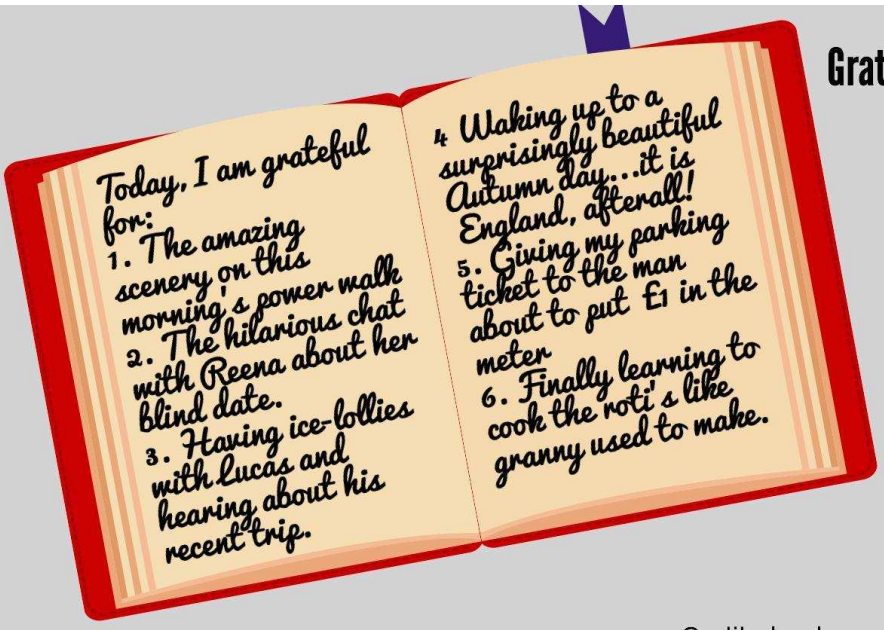
Programmes for health, including Yoga, Dancercise and Yoga

A wide range of courses for personal development and leisure, including art, photography, modern languages and cookery



Give


DO SOMETHING NICE FOR A FRIEND OR STRANGER, THANK SOMEONE, SMILE, VOLUNTEER YOUR TIME, JOIN A COMMUNITY GROUP, LOOK OUT AS WELL AS IN.
SEEING YOURSELF, AND YOUR HAPPINESS, LINKED TO THE WIDER COMMUNITY CAN BE INCREDIBLY REWARDING AND WILL CREATE CONNECTIONS WITH THE PEOPLE AROUND YOU
Helping others predicts reduced mortality specifically by buffering the association with stress and mortality
Upstream reciprocity
A single act of kindness typically inspires several more acts of generosity
occurs when an act of altruism causes the recipient to perform a later act of altruism in the benefit of a third party.
Individual level
Societal level
Evidence suggests that notions of reciprocity and 'giving back' to others promotes wellbeing for people of all ages. It offers a sense of purpose and makes you feel happier and more satisfied about life
Prosocial behaviour - including expressing gratitude and giving to others - is key to our psychological wellbeing.
The Physiology of Giving
The recipient is pleased to have recieved a small but meaningful gesture
As social animals we are hard-wired to get pleasure from helping others
The brain's reward centre is activated, the appearance of these positive feelings supports the upstream reciprocity process
When giving, areas of the brain associated with processing unexpected rewards become active releasing dopamine
The recipient is elevated, happy and grateful
Helper's high - release of endorphins, feelings of satisfaction and gratitude for what you have, pulls you away from self-preoccupation



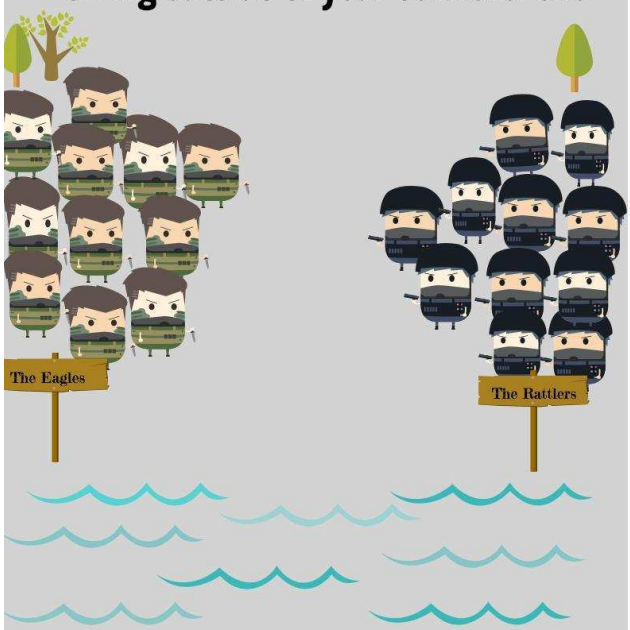
Writing in a gratitude journal is a way of radiating and generating more goodness for yourself as you are aware of all you have and not your have-nots

Strongly linked to positive mental health and life satisfaction, gratitude acknowledges connection. People who are grateful experience more happiness, love and zeal. While being protected from disparaging emotions such as greed , animosity and jealousy

Gratitude also reduces lifetime risk for anxiety, depression and substance abuse disorders. For individuals currently experiencing these issues, expressions of gratitude can help to heal and allow them to find closure for these problems. Leaving the individual with a profound sense that goodness exists, in the face of some very harsh realities.

Gratitude also benefits physical health, grateful people recover more quickly from illness, cope better with stress, and have lower blood pressure.

Giving outside of your comfort zone



The Robber's Cave Experiment, 1954

Twenty-two groups of boys who didn't know each other beforehand were invited to a special summer camp and put into two groups where pyschologist Muzafer Sherif tested the ability of competing groups to overcome their differences

The boys bonded within their groups, initially without knowledge of the other group. After group bonding had occurred situations arose where one group gained at the expense of the other group and a series of competitive games were arranged with a trophy for the winning group and individual prizes for winning team members . Soon the competition bred prejudice in the boys, initially in the form of taunting and name-calling. But it soon developed into flag burning, ransacking cabins, and fighting which had to be broken up by the camp organisers (who were actually researchers). All of which confirmed Sherif's conflict theory - conflict between groups can trigger discriminatory behaviour and prejudiced attitudes.

The researchers then integrated the groups with a number or reconciliatory and get-to-know-you activities. These contrived activities failed to bring the group together leading the researchers to devise scenarios that was beyond the resources and effort of one group such as the removal of a felled tree deemed a danger to camp, setting up tents without complete sets of equipment and moving a stalled truck carrying food. Finally there was an appreciable reduction in the tensions, with each boy helping towards the shared goals of the group. A sense of trust and cooperation developed strengthening ties to the group and turning enemies into friends.

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Harrow Community Click

Harrow Community Click is a way for people to help other in their community and rewarded for it- in time. For every hour of time you give helping someone, you receive one time credit. Harrow Community Click will also be running fun free activities in partnership with the local community.

These time credits can then be 'spent' when you need help from someone else. You could also give them to another person who needs some help or you could save them.

Volunteering in Harrow

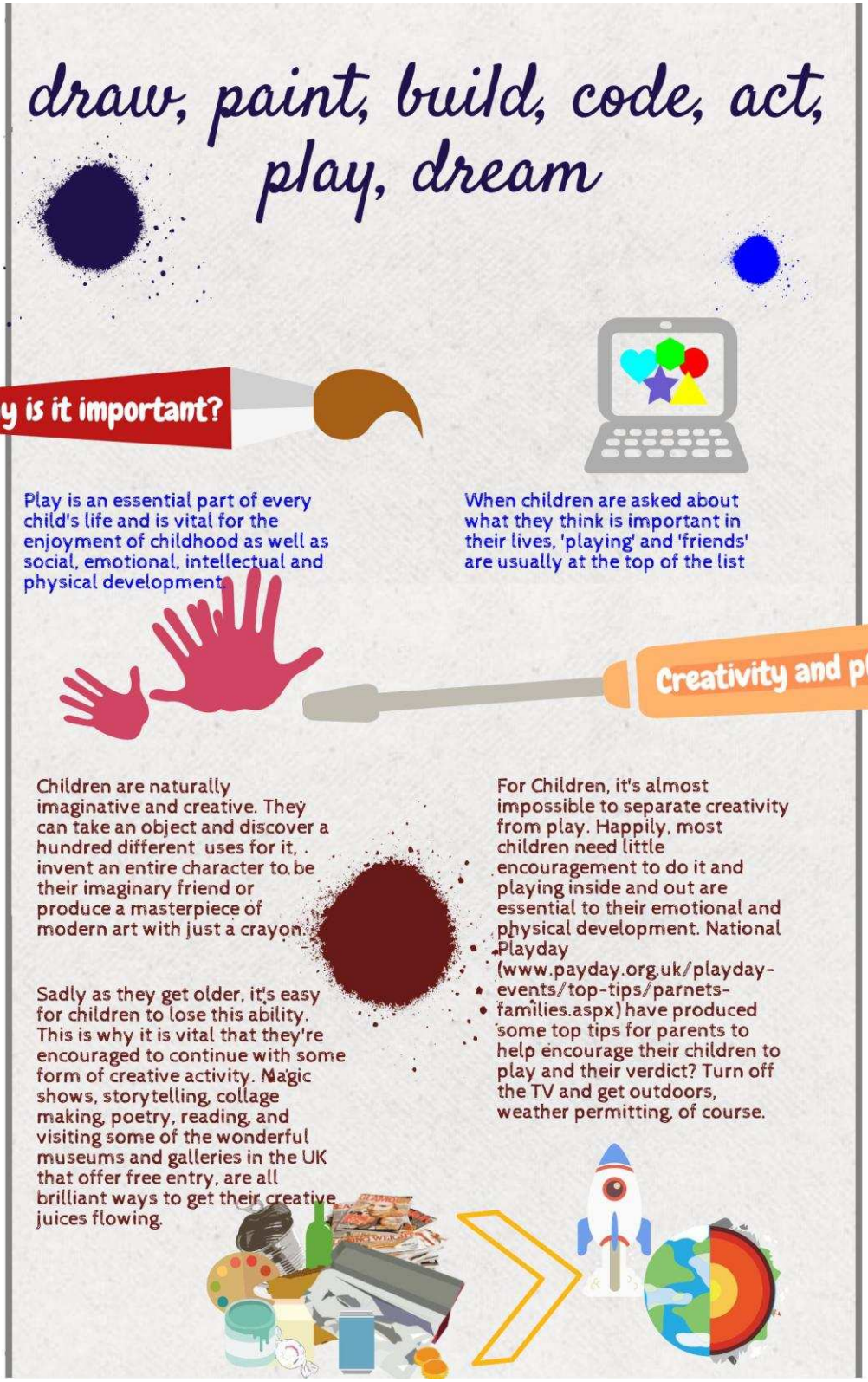
There are so many opportunities for you to give whether it be giving your time, money or expertise. People choose to volunteer for a variety of reasons. For some it offers the chance to give something back to the community or make a difference to the people around them.

For others it provides an opportunity to develop new skills, build on existing experience and knowledge or a route to employment. And yet for others volunteering appeals because of its social benefits. Regardless of the motivation, what unites all volunteers is the chance of finding work that is both challenging and rewarding.

Bharti (pictured above) is one of Harrow's volunteering queens. She volunteers for between six and seven organisations including MIND in Harrow and the police. She campaigns, with others, on behalf of service users and fights against unfair cuts. All of which helps her, her service users and the people of Harrow. Bharti also volunteers as a befriender

Giving is the ultimate expression of human relationships - people acting on behalf of their communities, because of a desire to contribute and help. When we asked Bharti what makes her happy, one of the first things she said was volunteering, quickly followed by looking after her family and friends, singing and dancing.

Be Creative & Play



How does play &creativity impact wellbeing?

Play has an impact on the architectural foundations of development such as gene expression and physical and chemical development of the brain. In turn, these foundations influence the child's ability to adapt to, survive, thrive in and shape their social and emotional environments.

Children's development and wellbeing cannot be understood as separate from their environment.

Play can help build resilience - the capacity for children to thrive despite adversity and stress in their lives. Emotions have a key role in playing and play makes a major contribution to developing emotion regulation, building strong attachments and peer friendships, engendering positive feelings and enabling children to cope with stressful situations through developing creative approaches and problem solving skills.

The benefits of play accrue from its characteristics of unpredictability, spontaneity, goalessness and personal control, rather than directly from its content.

Activities for children to get involved in

The National Trust have produced a list of 50 things to do before you're 11¾ (https://www.50things.org.uk/activity-list.aspx). The list ranges from going star gazing and building a den to setting up a snail race and making a mud pie.

Make a grass trumpet

Creativity for adults

There is no reason why creativity has to stop in childhood. Modern life has become more stressful in recent years and one way to manage this stress in a healthy and constructive way allowing the release of your inner child may be adult colouring-in books.

Art (including music, dance and drama) therapy has been shown to be a useful tool offering patients with mental illness a sense of control. It encourages self-expression, enhances coping skills, reduce stress, and boosts self-confidence.

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Play days

Playday is the national day for play in the UK, traditionally held on the first Wednesday in August

Coordinated by Play England and now in it's 28th year on Playday thousands of children and their families get out to play at hundreds if community events across the UK

As well as a celebration of children's right to play, Playday is a campaign that highlights the importance of play in children's lives.

From small-scale community events to thousands of children taking part in events organised in parks and open spaces - Playday is celebrated by each community in a way that suits them.

Playday events range from jubilee style street parties, festivals in parks or village greens, mass adventures in woodlands, fields even beaches, and public events at community venues.

As well as a celebration, Playday is an opportunity to campaign on issues affecting children's play. Each year, we call on everyone to celebrate Playday and show what play is fundamental for children's enjoyment of childhood, and vital for their health, wellbeing and development. In light of government cuts to play services across the country, it is more crucial than ever that we unite to stand up for play.

Whether you've got kids, you work with kids, or you're a big kid yourself, Playday needs you!

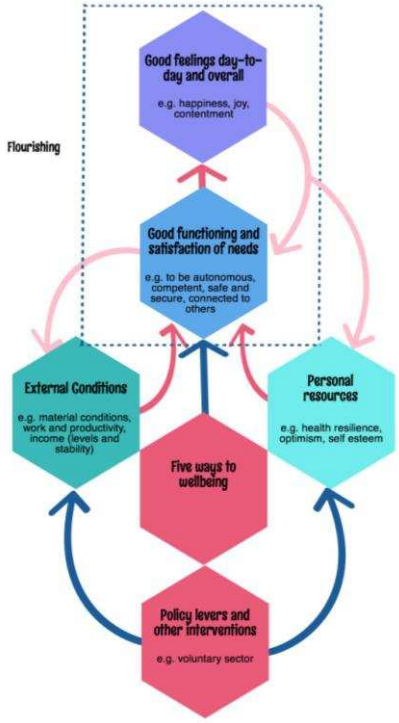
From local authorities to community groups, a wide variety of individuals and organisations get involved in Playday. There are lots of ways you can celebrate Playday and get involved in the wider campaign, why not: organise a celebration or spread the word, you can keep informed using Facebook and Twitter

Conclusion

Loneliness and social isolation are fast moving up the public health agenda, which highlights how impactful these two issues can be on quality of life. This report was intended to offer an insight into the things Harrow residents can do for themselves to help ameliorate the impact of these conditions on their lives.

NEF's five ways to wellbeing offer simple actions that residents can perform in their everyday lives to improve their wellbeing and the wellbeing of others, these actions can be used to reduce isolation and loneliness. This is exemplified in the dynamic model of wellbeing (figure 6). The model describes how an individual's external conditions act with their personal resources to enable them to function well in their interactions with the world and experience feelings of contentment - to flourish. The model also shows that aspects of wellbeing interlink with these external drivers - personal resources and external conditions. As a result, improvements made in one area will influence other parts of an individual's experience.

FIGURE 6 DYNAMIC MODEL OF WELLBEING



The model clearly shows that the five ways to wellbeing have a direct impact on an individuals wellbeing most likely because these actions combine elements of each driver. Explicitly demonstrating that it is what an individual does and not what they have that feeds positive wellbeing.

The campaign to end loneliness has stated that strategies to address loneliness and isolation should be undertaken in partnership, ensuring that interventions are delivered by all sectors. In order to build more resilient communities that resist loneliness and isolation, the evidence suggests that a community development approach alongside professional support yields the greatest impact. It is also an approach that offers value for money since small amounts of investment are required to achieve community action[15].

Harrow's public health team will continue to form strategic partnerships with health and wellbeing partners to ensure that we intervene to positively impact the external conditions of our residents and their personal resource in order to reduce the burden of social isolation and loneliness across the borough and in all age groups. These interventions will include, supportive relationship based interventions such as befriending, mentoring, gatekeeping, targeted support activities based on shared interests or other characteristics such as young carers or location based services such as community growing and group interventions with an educational focus.

The Health & Wellbeing strategy priority two states that we will empower the community and voluntary sector to collaborate with new sources of funding. We intend to do all we can to support the positive mental health and wellbeing of our residents but the power to truly flourish lies with our residents.

"Isolation is being by yourself; loneliness is not liking it."

-Older man from independent age focus groups

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REPORT FOR: HEALTH & SOCIAL CARE SCRUTINY SUB-COMMITTEE

Date of Meeting:	24 October 2015
Subject:	Harrow Health and Wellbeing Strategy
Responsible Officer:	Sarah Crouch, Consultant in Public Health
Scrutiny Lead Member area:	Councillor Michael Borio, Policy Lead Member & Councillor Mrs Vina Mithani, Performance Lead Member
Exempt:	No
Wards affected:	All
Enclosures:	Appendix A - Harrow Health and Wellbeing Strategy

Section 1 – Summary and Recommendations

The Harrow Health and Wellbeing Strategy enclosed with this report sets out the purpose and vision of the Harrow Health and Wellbeing Board for the next 5 years.

Recommendations:
For information only

Section 2 – Report

Introduction
The Harrow Health and Wellbeing Board was first established in 2011 and an initial strategy was developed in 2013 to guide action until the end of 2015. This strategy now needs to be refreshed to guide collaborative action for the next five years.

Background

Current situation
In the future, the Health and Wellbeing Board will focus on a small range of priorities, which are relevant to every Board member and where whole systems work can bring about significant change.

It is important to state that because of this approach, this strategy does not mention every disease, need, inequality or health and wellbeing-related issue in Harrow. The Health and Wellbeing Board have chosen to move away from a disease or deficit-focused approach (looking at what is wrong with health and wellbeing in Harrow) and instead focus on a model for enhancing health and wellbeing across the life course.

Why a change is needed
We know only 20% of the health of the population of Harrow is determined by the 'services' they receive so the new strategy adopts a life course rather than service development approach. Combined with the squeeze on public finances, Health and Wellbeing Board members need to think differently about how we invest for the future. We need to consider what residents will need in ten years and what we can do to enable people to live healthier lives for longer, reducing their need for public services. Prevention is better than cure. That does not just mean simply encouraging people to quit smoking, lose weight and improve their lifestyles – although that is important; a physically inactive person is likely to spend 37% more time in hospital and visit the doctor 5.5% more often than an active person[i]. However, the most important action we can take is to influence the circumstances in which we are born, develop, live, work and age – specifically our housing, education, employment, financial security and the built environment. The refreshed strategy therefore reflects this approach.

Implications of the Recommendation
The strategy is presented to the Health and Social Care Scrutiny sub-committee for information and discussion only prior to formal presentation to the Harrow Health and Wellbeing Board on 5 November 2015.

The Strategy has been developed with regard to the views of a range of stakeholders including Board members, staff and residents.

The Harrow Health and Wellbeing Board hosted an engagement event on 16 July 2015 where leaders from across the health and care system in Harrow,

along with politicians and residents came together to discuss how to work in partnership to improve wellbeing in Harrow**.** Additionally, a series of focus groups were held with a range of voluntary sector service users.

The comments from residents and voluntary sector representatives were drawn together into themes and these have informed the development of this Health and Wellbeing Strategy. The major themes that emerged were about the importance of the community and support provided within it, how much residents value the environment and neighbourhoods they live in and how they want good access to health and care services when they need them.

Healthwatch has also played a major part in shaping the content of this strategy.

Financial Implications

There is no budget assigned to the Health and Wellbeing Board and each organisation is facing considerable financial and capacity challenges.

This Strategy does not seek to create new work streams and action plans, and as a result is expected to be delivered within the existing financial envelope for partner organisations. It aims to facilitate smarter collaborative working across the health and wellbeing system and guide commissioning intentions for all engaged in improving wellbeing for Harrow residents. If successful, there should be a clear thread which joins Harrow Council, CCG, Healthwatch and the voluntary sector together.

There is a risk however that if existing funding arrangements for the Health and Wellbeing Board partners are reduced significantly, the Board will not be able to fulfil the vision and objectives set out in this strategy.

Performance Issues

A variety of health and wellbeing indicators will be monitored (and these are presented within the strategy) but they are intended to enable the Harrow Health and Wellbeing Board to retain an overview of health and wellbeing in the borough rather than serve as a performance management tool. An annual action plan will be developed each year and implementation will be reported in an annual report.

Environmental Impact

The Harrow Health and Wellbeing Strategy sets out an ambition to support all in Harrow to start, live, work and age well. Part of ‘living well’ is considering the extent to which the environment influences health and wellbeing. Over the next five years the Harrow Health and Wellbeing Board will therefore be looking for ways to assess the impact of environmental change e.g. regeneration schemes, on health and wellbeing, how to enhance positive effects and mitigate negative effects.

Risk Management Implications

There is a risk that if existing funding arrangements for the Health and Wellbeing Board partners are reduced significantly, the Board will not be able to fulfil the vision and objectives set out in this strategy. The Board will adopt a flexible approach, working closely together to ensure that the work of the Board is realistic and achievable.

Equalities implications

Was an Equality Impact Assessment carried out? Yes – under development based upon the action plan agreed. The Strategy sets out an approach to improve the health and wellbeing of the whole population of Harrow. It highlights health inequalities associated with deprivation particularly and reinforces the need for approaches which target and reach those groups with the greatest needs.

Council Priorities

The Council's vision:

Working Together to Make a Difference for Harrow

Please identify how the report incorporates the administration's priorities.

- Making a difference for the vulnerable

The strategy highlights the unacceptable differences between people living in different parts of Harrow and the Health and Wellbeing Board's desire to narrow the six-year gap in life expectancy across the borough.

- Making a difference for communities

The Strategy talks about helping people to live well, a large component of which is about community cohesion but also about how important the environment people live in – their housing, high streets and green spaces – are to resident's health.

- Making a difference for local businesses

One element of the Strategy is to support Harrow residents to 'work well'. The Harrow Health and Wellbeing Board is keen to find opportunities to help people in Harrow to be financially secure by finding good jobs and staying in work in an organisation which promotes health and wellbeing. Engaging with local businesses will be key to successful achievement of this objective.

- Making a difference for families

The strategy highlights the need to support children from the womb to adulthood to be safe, happy and have every opportunity to reach their full potential. Children need to be loved and nurtured if they are to achieve long term physical, mental and emotional wellbeing. Good attachment with our parents and carers in early life are important so a family focused approach is critical to help children have the best start in life.

Section 3 - Statutory Officer Clearance

Not required.

Ward Councillors notified:	**NO**

Section 4 - Contact Details and Background Papers

Contact: Sarah Crouch, Consultant in Public Health Tel: 020 8736 6834

Background Papers: List **only non-exempt** documents (ie not Private and Confidential/Part II documents) relied on to a material extent in preparing the report (eg previous reports). Where possible also include a web link to the documents.

[i] Sari N. Physical inactivity and its impact on healthcare utilisation. Health Econ. 2009; 18:885-901

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Harrow Health and Wellbeing Strategy 2016-2020

Contents

1. Foreword

This is no ordinary foreword. This is no ordinary strategy. I hope that this is the time that people in the year 2020 will point to and say 'that was when the health, care and wellbeing system started to change in Harrow.'

In this Strategy, we have, as you might expect, summarised what the key issues in Harrow are and signposted you to further information. We have also highlighted the unacceptable differences between people living in different parts of Harrow and our desire to narrow the 6-year gap in life expectancy across the borough. Clearly these are the things that the Health and Wellbeing Board and I hope you, want to address as a matter of urgency.

But this Strategy is not about developing a long list of new actions to address all these needs in Harrow. It's about how we initiate a new way of working together as residents, as doctors and nurses, as councillors, as police officers, as housing staff, as social workers, as volunteers, as refuse collectors, as job centre staff, as environmental health officers, as managers; as entrepreneurs running local businesses; as people who care about living and working in Harrow.

The Health and Wellbeing Board want to develop a Health and Wellbeing Strategy that all of you identify with and that you quote because you believe in it, not just because it ticks a box.

Regardless of your role or job title, you are undoubtedly already making a difference to the health and wellbeing of people in Harrow. Did you know that only 20% of our health in Harrow is determined by Northwick Park A&E, CNWL mental health teams, your GP and the whole host of other health 'services' we receive? They are of course essential components but it is the circumstances in which we are born, develop, live, work and age – specifically our housing, education, employment, financial security and the built environment – which make the most difference to the largest number.

Perhaps like me, when you were young you enjoyed joining the dots up and making a picture. The purpose of the Health and Wellbeing Board in Harrow is to provide leadership for that joined up, 'big picture' way of working.

For the next 5 years, our goal is to enable everyone in Harrow to start well, live well, work well and age well. When we talk about 'wellbeing' in this context, we mean mind, body, heart and spirit as you have told us they are all inextricably linked.

Clearly this is an ambitious vision and regretfully statutory authorities don't have the resources now to continue 'business as usual'. Leaders continue to advocate for a better deal for health in Harrow but it's time to embrace different thinking. We are all the co-producers of health and wellbeing rather than the recipients of services. We all have power to change the system and it is our collective responsibility to come to the table with solutions.

You have said you want the Health and Wellbeing Board members "to be partners not the bosses" who work better with you to make a difference to health and wellbeing in Harrow. We hope you see the role we can all play and will join together in making this vision a reality.

Anne Whitehead

2. Summary of Harrow Health and Wellbeing Board strategy 2016-20

Summary of
Health and Wellbeing Board
Ambition 2016 - 2020

Mission: To provide the leadership to enable everyone living and working in Harrow to join together to improve health and wellbeing.

Vision: To help all in Harrow to start, live, work and age well concentrating particularly on those with the greatest need.

Objectives:

Start Well

We want children from the womb to adulthood to be safe, happy and have every opportunity to reach their full potential.

Live Well

We want high quality, easily accessible health and care services when we need them and sufficient and good quality housing, green and active spaces, healthy high streets and neighbourhoods.

Work Well

We want to help people to be financially secure by finding good jobs and staying in work in an organisation which promotes health and wellbeing.

Age Well

We want to enable older people to remain well, connected to others and independent in their own homes for longer and enable dignified deaths.

Priorities:

1. Use every opportunity to promote mental wellbeing
2. Empower the community and voluntary sector to collaborate to deliver alternative delivery models and funding solutions
3. Provide integrated health and care services

Performance:

It is proposed that the Harrow Health and Wellbeing Board monitor and evaluate implementation of this strategy as follows:

- ★ **Monitor local health and wellbeing outcomes:** This is not a performance management tool but will focus attention on overall population health and wellbeing and health inequalities and inform future work.
- ★ **Monitor implementation of specific annual actions:** Quarterly and annual monitoring of actions will be established and an annual action plan will be refreshed by December each year.
- ★ **Undertake an annual partnership health check:** An annual partnership appraisal will be conducted to show we are serious about collaborative working.

Principles:

- ★ We will work in partnership, where possible sharing resources
- ★ We will use evidence of what works to inform our actions
- ★ We will act to have a long term sustainable impact
- ★ We will innovate but evaluate
- ★ We will be flexible and review action according to changing need and context.
- ★ We will be flexible and review action according to changing need and context

Process:

- ★ **We will explore new health and wellbeing innovation forums** in the community to enable a much wider group of residents and stakeholders to get involved in the work of the Health and Wellbeing Board.
- ★ **We will create networked groups:** We will support the development of networks to connect those interested in 'start well', 'live well', 'work well' and 'age well' themes.
- ★ **Themed agendas:** Where possible, the Health and Wellbeing Board agenda will be split according to the start, live, work, age well themes.
- ★ **There will be a clear relationship between the Health and Wellbeing Strategy and the approach of the Health and Wellbeing Board:** Board members will review all papers considering the three priority areas, the start, live, work and age well themes, the influence of the social determinants of health and impact on inequalities.
- ★ **We will explore new ways of communicating with residents:** A digital newsletter summarising the work of the Health and Well-being Board will be produced every 3 months and we will explore other new ways of communicating with residents including through social media.
- ★ **We will co-ordinate health and wellbeing engagement:** We will try to bring people together once to discuss several issues rather than separately for each organisation and have connected plans for engagement available to all our stakeholders.

Harrow Council LONDON · healthwatch Harrow · NHS Harrow Clinical Commissioning Group · hib · NHS England · Voluntary sector Logo(s)

3. What is the Health and Wellbeing Board, what has it done to date and why do we need a new strategy?

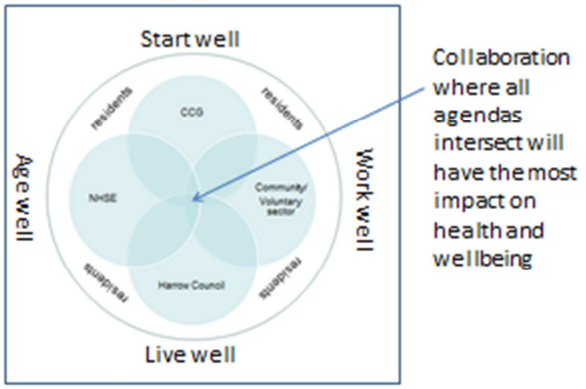
Each local authority has to have a Health and Wellbeing Board. The idea of the Board is that partners work together to achieve more than we could alone. The Board is a partnership between Harrow Council, specifically Adult Social Services, Public Health and Children, Schools and Young people, Harrow Clinical Commissioning Group, NHS England, Healthwatch and the voluntary sector.

The Harrow Health and Wellbeing Board was first established in 2011 and an initial strategy was developed to encapsulate the Board's vision for 2013-15. This strategy now needs to be refreshed to guide collaborative action for the next five years.

The stated purpose of the previous Health and Wellbeing Strategy was to work together, to improve health and wellbeing and quality of life of people of Harrow, to reduce health inequalities, to promote independence, have a long term and sustainable impact, to guide commissioning intentions of member organisations - get the best value for funding available through effective commissioning, to build capacity to deliver public health programmes in the third sector, front line services and business sector.

Seven priority areas were chosen as areas for focus for 2013-15. These were long term conditions, cancer, worklessness, poverty, mental health and wellbeing, supporting parents and the community to protect children and maximise their life chances and dementia. A commitment was made to consider prevention, early detection, intervention and services, reablement and end of life issues. Six joint commissioning intentions were established and related 'Task and Finish groups' were established to take action. Appendix 1 outlines the progress report which the Task and Finish groups submitted to the Harrow Health and Wellbeing Board in 2013.

In the future, the Health and Wellbeing Board will focus on a much smaller range of priorities, which are relevant to every partner and where whole systems work can bring about significant change as the diagram below illustrates.



It is important to state that because of this approach, this strategy does not mention every disease, need, inequality or health and wellbeing-related issue in Harrow although section 7 does draw on the Joint Strategic Needs Assessment to highlight some of the key needs in the population. The Health and Wellbeing Board have chosen to move away from a disease or deficit-focused approach, looking at what is wrong with health and wellbeing in Harrow, and instead focus on a model for enhancing health and wellbeing across the life course.

There is no budget assigned to the Health and Wellbeing Board and each organisation is facing considerable financial and capacity challenges. This Strategy does not seek to create new workstreams and action plans. It aims to facilitate smarter collaborative working across the health and wellbeing system and guide commissioning intentions for all engaged in improving wellbeing for Harrow residents. If successful, there should be a clear thread which joins Harrow adult social care, children's services, public health, CCG, Healthwatch and voluntary sector together. We hope additionally however that this strategy will inform and inspire the commissioning intentions of a much wider workforce including health service providers, housing, environmental health, economic development, planning and police.

4. What do we mean by health and wellbeing?

It's important we take time here to identify what we mean by health and wellbeing because if we fail to define it, we cannot measure the impact we have on it. The words themselves mean different things to different people. The Somali community told us 'we have no word for wellbeing' for example.

We know things it's not. It's not just the absence of disease since it's perfectly possible to have a physical or mental illness and still have a sense of wellbeing.

One phrase from a resident seems to encapsulate what many of you said health and wellbeing means to you:

"It's about mind, body, heart and spirit"

- *Mind* – the thoughts and emotions we have and the feelings we have about ourselves and others
- *Body* – our physical being and appearance
- *Heart* – the love and connections we share with others
- *Spirit* – our sense of purpose in life

They are all intertwined and cannot and should not be viewed as separate entities. Mental illness has been shown to precede physical illness such as heart disease, stroke, and cancer[1] and vice versa, almost a third of people with a long term physical health condition also have a mental illness which may be biological or as a result of reduced capabilities and social connections. The co-existence of mental and physical illness has been shown to reduce quality of life, impair physical recovery and may also increase risk of non-compliance with treatment. Evidence suggests connecting with other people, being active, continuing to learn, giving to others and being aware of the present moment – your thoughts, feelings and the world around you – can all improve our wellbeing.

5. What works to improve health and wellbeing?

We know only 20% of the health of the population of Harrow is determined by the 'services' they receive. Combined with the squeeze on public finances, Health and Wellbeing Board members need to think differently about how we invest for the future. We need to consider what residents will need in ten years and what we can do to enable people to live healthier lives for longer, reducing their need for public services. Prevention is better than cure. That does not just mean simply encouraging people to quit smoking, lose weight and improve their lifestyles – although that is important; a physically inactive person is likely to spend 37% more time in hospital and visit the doctor 5.5% more often than an active person[2]. However, the most important action we can take is to influence the circumstances in which we are born, develop, live, work and age – specifically our housing, education, employment, financial security and the built environment.

Leading health inequality thinker, Michael Marmot, says that to reduce health inequalities, we must take actions which will benefit everyone but with a greater emphasis and intensity on those who are more disadvantaged as they are disproportionately affected by poor health and wellbeing.

6. What do Harrow residents think will improve health and wellbeing?

To inform discussions about what the Harrow Health and Wellbeing Strategy for the next five years should look like, the Health and Wellbeing Board hosted an engagement event on 16 July 2015 where leaders from across the health and care system in Harrow, along with politicians and residents came together to discuss how to work in partnership to improve wellbeing in Harrow. Discussions on the day moved from frustrations with the current system to solutions for the future and there was an appetite for the Harrow Health and Wellbeing Board to provide the leadership to enable everyone living and working in Harrow to join together to improve health and wellbeing. The visual minutes from this day are presented in appendix 2.

Additionally, a series of focus groups were held with Age UK Harrow, Harrow Carers, Harrow Mencap, Mind in Harrow, Youth Parliament, Citizens Advice Bureau and the Voluntary Sector Forum. These focus groups gave participants the opportunity to reflect on what health and wellbeing means to them, how living in Harrow positively and negatively affects wellbeing and what everyone could commit to doing differently that would improve health and wellbeing.

The comments from residents and voluntary sector representatives were drawn together into themes and these have informed the development of this Health and Wellbeing Strategy. The major themes that emerged were about the importance of the community and support provided within it, how much residents value the environment and neighbourhoods they live in and how they want good access to health and care services when they need them. When asked, 'What could we all do that would improve health and wellbeing in Harrow?' the following solutions were proposed.

Build up communities and help people do more for themselves and each other
"I have no family – I live on my own. It would be nice if neighbours came to help."

"Ban on khat has been difficult because took away a social environment. No excuse to meet now "

"Carers Forum makes a difference – not just caring but allowing people to have breaks, learn skills, have fun and socialise."

"Volunteering is a massive success story across the borough."

"Happy news needs reporting more widely to build trust in communities."

Improve access to services and facilities
"Culturally appropriate services such as women only swimming sessions and more use of interpreter phone system – we may not want to involve relatives"

"A&E is closer than Alexandra Avenue."

"I need more time than 10 mins for appointments when you have more than one health problem"

"Foodbanks need for fresh food not just tinned."

"More investment in Mental Health and more access to talking therapies and more awareness in schools to spot the signs and invest in things for young people to do."

Signpost to services and integrated working

"Ensuring that there is less duplication and better awareness of what everyone is providing."

"There are platforms which aim to signpost but no pathways and we keep re-inventing and duplicating."

"It would be helpful if people worked together more. Joined up working. If people talked to each other."

"Advice and information service in GP surgery would help address the underlying problems rather than GPs just giving out pills."

"Luton one stop shop is a good model – front of house display of voluntary sector groups before anyone sees Council."

"More awareness about volunteering would increase the capacity."

Address the social determinants

"Housing shortage is big problem."

"Lifting out of poverty helps – huge debt problem in Harrow – hidden issue."

"People need help to find employment, especially if they have a health problem which is a barrier."

"Energy deals to reduce the number of people living in cold homes."

"Schools in Harrow are good but problem for local people getting in."

"Food Bank is good but no use for homeless people who have no where to cook."

"Safety is an important issue – interpersonal violence is prevalent and needs to be addressed – overcrowding increases the problem."

Improve Harrow through regeneration

"Harrow is very green – lots of parks but not enough Council leisure facilities."

"Government need to help and create a better environment for people to live in – e.g. stop fast food restaurants opening near schools, making healthy food cheaper (salad is more expensive than chips and cookies)."

"Pinner/Hatch End are nice and healthy but other areas do not have the same vibe – there is a disparity between this and South Harrow."

"Flash new developments in Town Centre, South Harrow being missed out - needs to be gentrified too."

"Need to give the area a bit of vibrancy, no more flats."

7. Where are we now in Harrow?

The Health and Wellbeing Board have thought in detail and consulted you about what we could achieve better together. They have used the Harrow Joint Strategic Needs Assessment (JSNA) to help inform their judgements about where we are now .
The JSNA says a lot about what is good in Harrow. It is generally a healthy place and we perform better or similar to national levels for many health indicators although there are a few indicators where Harrow performs worse than the England average such as:

- High rate of statutory homelessness
- High rate of fuel poverty
- High percentage of adult social care users who do not have as much social contact as they would like
- High rates of low birthweight babies
- High rates of excess weight in 10-11 year olds
- Low amount of fruit and vegetables eaten
- Low amount of exercise taken
- People entering prison with substance misuse problems who are not already known to community services
- Low rates of cervical cancer screening
- Low rates of health checks
- Low rates for HPV, PPV and flu vaccination
- High rates of late diagnosis of HIV
- High rates of TB
- High rates of tooth decay in children

We need to be mindful of ensuring that we understand not just how Harrow differs from other boroughs in England but how different population groups within Harrow have very different levels of health and wellbeing. For example, the JNSA tells us there is a 3-fold increased risk of diabetes among people of South Asian origin compared with white people and risk increases at a younger age and lower weight. Older people are at greater risk of falls and associated injury, such as hip fractures, which is associated with a greater need for institutional care. We need to use the intelligence provided in the JSNA to best effect and target our action where it will have the most impact for those at greatest risk of poor health and wellbeing.

One of the key factors which cuts across all these issues is deprivation. In general, poor health indicators are found in the more deprived parts of the borough and better outcomes in the more affluent parts. On average, baby girls born in Pinner South can expect to live more than nine years longer than baby girls born in Wealdstone. Baby boys born in Headstone North can expect to live for more than eight years longer than baby boys in Wealdstone. It's no coincidence, given our income and financial security are important determinants of health and wellbeing, that we find poverty is linked to this inequality; we know 42% of children in Wealdstone are living in poverty compared to 9.3% in Pinner South. We need to urgently address this inequality and ensure that **everyone** in Harrow has an opportunity to start, work, live and age well – the Health and Wellbeing Board vision for Harrow.

It's important to emphasise that more services aren't the only answer here. Education, employment, the environment we live in, our neighbours and the amount of money we have are the most important determinants of our health. The Harrow Health and Wellbeing Board have a key opportunity to join together to influence these social determinants of health.

8. Harrow Health and Wellbeing Board mission

The mission of the Health and Wellbeing Board is to:

Provide the leadership to enable everyone living and working in Harrow to join together to improve health and wellbeing.

That means we will:

- Help bring those with an interest in health and wellbeing together.
- Ensure the needs of Harrow residents drives decision making.
- Identify where we can achieve more together than alone.
- Facilitate joint working to improve health and wellbeing.

9. Our vision

The vision of the Harrow Health and Wellbeing Board is

To help all in Harrow to start, live, work and age well concentrating particularly on those with the greatest need.

By this we mean:

- *Start well* – we want children from the womb to adulthood to be safe, happy and have every opportunity to reach their full potential
- *Live well* – we want high quality, easily accessible health and care services when we need them, sufficient and good quality housing, green and active spaces, healthy high streets and neighbourhoods
- *Work well* – we want to help people to be financially secure by finding good jobs and staying in work in an organisation which promotes health and wellbeing
- *Age well* – we want to enable older people to remain well, connected to others and independent in their own homes for longer and enable dignified deaths

The focus of Health and Wellbeing partners in the future should be on how they can contribute to making Harrow a better place to live and reduce the differences in life expectancy and healthy life expectancy between communities.

9.1 Start well

"We want children from the womb to adulthood to be safe, happy and have every opportunity to reach their full potential."

9.1.1 Why is it important?

This is where the foundations for lifelong health and wellbeing are laid. A child's positive and negative experiences during pregnancy and the early years of life have a major impact on their health, wellbeing and life chances in later childhood and beyond into adult life. Harrow is home to 55,800 children aged 0-17. In 2014, around 3100 of these children were in need of support from social services. This includes children 'looked after' by the Council, the main reason for which is due to neglect or abuse[3]. These children are vulnerable; whilst some do well, a disproportionately high number are reported to have emotional and mental health problems and a high proportion experience poor health, education and social outcomes after leaving care[4]. In Harrow, the proportion of children looked after who are cautioned or convicted has also been historically high. These children should have the same opportunities as other children and young people. Integrated health, care and education provision can make a lifelong difference to children in Harrow.

9.1.2 Factors in childhood which promote health and wellbeing

- Children need to be loved and nurtured if they are to achieve long term physical, mental and emotional wellbeing[5]. Good attachment with our parents and carers in early life are important.
- A child's early development score at 22 months is an accurate predictor of educational outcomes at age 26[6] which is in turn related an individual's job position, which influences income, housing and other material resources, which in turn affect long-term health outcomes[7]. Effective parenting, as well as integrated health, care and education provision can enable young children to acquire the social and emotional skills to be ready for school. It can also prevent common mental and behavioural disorders in childhood, such as conduct disorder[1] and cultivate positive attitudes and behaviours leading to healthier habits in adulthood.
- Physical activity is an important component of early brain development and learning as well as physical health. Children in deprived areas are nine times less likely to have access to green space and places to play[8].
- Breastfeeding reduces illness in young children, has health benefits for the infant and the mother and results in cost savings to the NHS through reduced hospital admission for the treatment of infection in infants[9].
- Immunisations protect children from a range of infectious diseases and high rates of immunisations means diseases are less likely to circulate and cause illness in vulnerable groups who cannot be vaccinated.
- Screening facilitates early identification of those who may have a health or developmental issue and could benefit from early intervention.

9.1.3 Factors in childhood which put future health and wellbeing at risk

- Babies born below normal birth weight are more vulnerable to infection, developmental problems and even death in infancy as well as longer term consequences such as cardiovascular disease and diabetes in later life[10]. Low birth weight can be caused by a variety of factors but there is particular concern to eliminate smoking and substance use in pregnancy as a cause.
- Childhood poverty leads to premature mortality and poor health outcomes for adults[11]. Children from poorer backgrounds are also at more risk of poorer development.
- "Children of mothers who have postnatal depression are less likely to show secure attachment at 36 months, are more likely to have social, emotion and cognitive problems at age 5 and are more likely to experience depression by 16 years[12]".
- Poor mental health in children and young people is linked to self-harm and suicide, poorer educational attainment and employment prospects, antisocial behaviour and offending, social relationship difficulties and health risk behaviour (smoking, substance misuse, sexual risk, poor nutrition and physical activity). Half of adult mental health problems start before the age of 14. Child adversity of all forms accounts for 30% of adult mental disorder[13]. Looked after children are therefore more vulnerable to poor mental health.
- Childhood obesity increases the risk of cardiovascular disease and diabetes in later life. In Harrow childhood obesity rates are increasing with 9.3% of Reception aged children being overweight or obese (2013/14) increasing to 20.8% for children aged 10 to 11 years old in year 6. Low levels of physical activity and high levels of fat and sugar in children's diet are a significant cause, the sugar also leading now to a significant amount of preventable tooth decay in children as young as five years old.
- More than 8 out of 10 adult smokers started before age 19[14] increasing risk of cancer and cardiovascular disease.

[1] Conduct disorder is persistent patterns of antisocial, aggressive or defiant behaviour that amount to significant and persistent violations of age-appropriate social expectations. NICE 2014.

- Youth offending could be a consequence and cause of unmet health needs.

9.2 Live well
"We want easily accessible, high quality health and care services when we need them, sufficient and good quality housing, green and active spaces, healthy high streets and neighbourhoods."

9.2.1 Why is this important?
We know only 20% of the health of the population of Harrow is determined by the 'services' they receive. The most important action we can take is to influence the circumstances in which we live – specifically our housing, the environment and neighbourhoods we inhabit.

9.2.2 Factors which promote health and wellbeing

- *High quality health and care services*
  There are 34 GP surgeries and 62 pharmacies in Harrow. GPs are the first point of contact for residents needing health care assistance and can signpost to a range of services. The ease with which we can access the services of our GP influences our decision to continue to use these services as our first port of call, along with the confidence we have in our physician[15].

  There is much scope for pharmacies to play a leading role in Harrow in supporting health and wellbeing and particularly in reaching out to those most in need and reducing the burden on overstretched GP practices. Many pharmacies already provide a range of health promoting services – such as smoking cessation, sexual health and health checks but there are opportunities to do more and reach more people given the pharmacies are often located in prominent locations, are open at weekends and do not require appointments to be made.

- *Good quality housing*

Good housing is a foundation for life, not just health. Poor quality housing – damp, mould, cold and overcrowding - is associated with increased risk of cardiovascular and respiratory disease as well as anxiety and depression and accidents in the home. Homes provided by Harrow Council may be good quality but there is an inadequate supply – hence a new building programme is planned. In the meantime, housing quality may be poorer in the private rented sector where residents may be temporarily housed or 'permanently' living as they are not eligible for support from the local authority. Harrow has one of the highest rates of fuel poverty in London – implying that many of our residents are living in cold homes which may be having a knock-on impact on their health. It is also important to consider the needs of an ageing population who are owner occupiers but whose homes pose risks to them. Aids and adaptions may help people live independently for longer.

- *Green and active spaces*

There is significant evidence that access to good quality green spaces can offer a number of health benefits including reduced weight, improved mental health and wellbeing (such as depression, stress and dementia) and increased longevity[16]. This is in addition to environmental benefits – such as improved air quality, improved community cohesion and satisfaction with 'place', which have indirect impacts on health[17]. In Harrow as nationwide, people living in the most deprived areas of the borough are less likely to live near green space. It is no surprise that these areas are also associated with the lowest rates of physical activity and higher rates of obesity and cardiovascular disease. Increasing green space in areas where it is scare may have social and economic benefits and may reduce health inequalities. Furthermore, encouraging and creating an environment where more people are motivated to swap their car for walking, cycling or public transport would have an impact on

physical activity and reduce related health inequality as well as potentially reducing injury and deaths from traffic collisions – again more prevalent in lower social economic groups[18].

- *Healthy high streets and neighbourhoods*

A healthy high street and neighbourhood is one in which there is 'clean air, less noise, more connected neighbourhoods, things to see and do, and a place where people feel relaxed'[19].

Source: Royal Society for Public Health. The Health on the High Street

We need to think about designing our high streets to encourage active and healthy lifestyles. Pavements, seating, shade and shelter are all important urban design principles. The types of shops on the high street is also important but has changed over time due to the development of out of town and internet shopping combined with the economic downturn. There is an opportunity to reinvent high streets across Harrow, particularly in light of the 'Heart of Harrow' regeneration agenda. Pinner and Stanmore have been rated in the top 10 healthy high streets in London because they have a higher proportion of businesses which encourage healthy lifestyle choice, promote social interaction, allow greater access to health care services and/or health advice and promote mental wellbeing[20]. Unfortunately, many other high streets in Harrow have instead been taken over by fast food restaurants, betting shops and licensed premises. Research in Harrow has shown that the most deprived areas of the borough have the highest number of fast food outlets and many of these are located in close proximity to schools, actively targeting children through price promotions. Many more meals are now eaten outside of the home which is great for economic development but it is important that we don't trade economics for health – it's a false economy in the long run. High levels of salt, fat and sugar ruin our cardiovascular health and many research studies have found a direct link between fast food in high streets and higher obesity rates.

Neighbourhoods should provide a safe environment where residents do not live in fear of crime, violence, harassment or accidents. Harrow has the lowest overall crime rate in London however only 2 in 5 residents say they think it is safe or fairly safe after dark which is lower than the London and England average. Of course we not only deserve safe neighbourhoods to live in but to be safe within our own homes. An estimated 5617 women and girls aged 16-59 in Harrow were reportedly a victim of domestic abuse in the past year[21]. This abuse, whether physical, emotional, psychological, financial or sexual can have devastating consequences both for the victim and their family – 90% of incidents in family households occurred with a child in the next room and 50% involved abuse of children.

Individuals with strong social networks live longer and are more likely to be 'housed, healthy, hired and happy.'[22] Volunteering is good for health and wellbeing[23]. Places with increased contact and interaction between people tend to have greater community spirit[24]. Conversely, lack of social networks and support can lead to loneliness, social isolation and these are associated with poorer physical health.

9.3 Work well

"We want to help people to be financially secure by finding good jobs and staying in work in an organisation which promotes health and wellbeing."

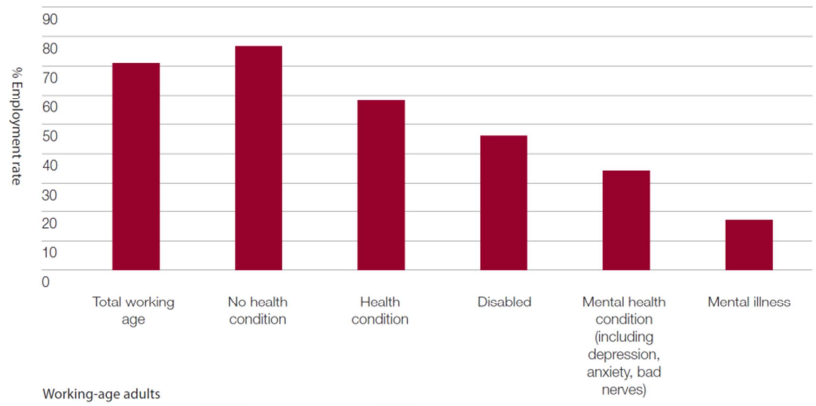
9.3.1 Why is this important?

Being in a job is good for health, provided it is good quality work. This is because not only does employment provide for our material needs but our jobs are often wrapped up with our identity, self-esteem and status, all of which affect our physical and mental wellbeing[25].

Conversely, unemployment is directly associated with poor mental and physical health including cardiovascular disease, depression and suicide plus those out of work are more likely to smoke, drink alcohol and be physically inactive[26].

There are 158,300 working age people (16-64) in Harrow which is 65% of the total population[27]. We have about 3,802 (2.4% of the working age population) currently unemployed[28] although higher rates in wards close to the town centre and south-west of Harrow such as Wealdstone (4.4%) and Marlborough (4.1%). Harrow also has a high number of young people in education, employment, or training in the country - at 97.3 per cent.

The relationship between unemployment and health is partly because losing your job worsens your health but also because those who have worse health already due to long term illness or disability are less likely to be employed. Those with mental health problems in particular have very low rates of employment as demonstrated by the graph below; nationally only 37% are employed compared to 71% employment rate in the working age population. Poor mental health is also a leading cause of sickness absence from work.



Source: Institute of Health Equity. 2014. Increasing employment opportunities and improving workplace health. Local action on health inequalities: Health Equity Evidence. Review 5. London: PHE/IHE.

Rates of unemployment are higher in those in lower socio-economic groups and if they are employed, they are more likely to be in low paid or poor quality work, potentially due to poorer qualifications[29]. This is, in part, why there are health inequalities with those in lower socio-economic groups being at greater risk of poorer health than those higher up the social gradient. What's more, our social position affects whether we are likely to retain work if we do develop a long term condition; non-manual workers are more likely to remain in work if they have a limiting illness compared to those in manual occupations[30].

Rates of unemployment are also higher in those with caring responsibilities, lone parents, those from some ethnic minority groups, older people and young people.

The longer you are unemployed, the more likely your health is to suffer and the less likely you are to get back to work.

It is important to emphasise that not every job is associated with health benefits. "Jobs that are insecure, low-paid and that fail to protect employees from stress and danger make people ill"[31]. Conversely, those working environments that provide a positive working culture – good social support, where employees have control over their work and the way the organisation works, are treated fairly and appropriately rewarded are likely to have better health.

Wages in Harrow are generally lower than in London and in West London as a whole. People working in Harrow earn, on average, less than the average weekly pay for London residents. The skills and employment profile for Harrow shows a high proportion of people in the lower paid sectors of process industries and sales and customer services.

9.3.2 Factors which promote health and wellbeing

- Good psychosocial working conditions
- Good access to jobs across the social gradient
- Support for those who are disadvantaged in the labour market to get and keep a job
- Good quality jobs for all
- Better working conditions, particularly for older people

9.3.3 Factors which put future health and wellbeing at risk

- Temporary workers who are dissatisfied with insecure work situation have higher mortality than permanent employees
- Those working long or irregular working hours or shift work
- Those with fewer qualifications and skills are more likely to experience poorer working conditions and poorer health
- Long term illness or disability
- Young people not in education, employment or training are at greater risk of poor health, depression and early parenthood which can result in poorer health and wellbeing outcomes for the teenage parent and child. The longer they are out of education, employment or training, the less likely they are to find work in the future.

9.4 Age well

"We want to enable older people to remain well, connected to others and independent in their own homes for longer and enable dignified deaths."

9.4.1 Why is this important?

Harrow has one of the highest older people populations in London. There are 37,200 people over the age 65 living in Harrow and this is set to rise by around 12% by 2020 (Projecting older people population).

An older person's ability to continue to care for themselves, retain their independence and have choice and control over their care including end of life planning when they need it, alongside a system that offers prevention and early diagnosis all have a major impact on health and wellbeing. Many of these older people rely on informal support provided by family members – 33% of whom are over 65 themselves - and it is therefore vital that we also consider the health and wellbeing of the 24,620 carers in Harrow[32]. This number has increased by almost 20% in the last ten years and puts Harrow with the second highest number of carers in London.

Harrow is also expecting an increase in the number of older people with learning disabilities over the next 15 years due to increased survival rates and birth rates which may have an impact on service provision.

Harrow's older population (65 and older) is roughly broken down into two thirds White British (66%), under one third Asian / Asian British (27%) and Black / Black British (4%). Over the next thirty years these figures will change and as the population ages, the Asian / Asian British population will become the largest ethnic group in Harrow for older people. The growth of the older Asian / Asian British population (with a minimal rise in the Black / Black British population) will provide unique challenges for Harrow in terms of dementia and tailored approaches to improving wellbeing.

9.4.2 Factors which promote health and wellbeing

- Physical activity and mental stimulation
- Family and social networks
- Living safely in own homes
- Maintaining personal dignity and independence
- Support for carers since 33% of carers are aged 65 years and over
- Maintaining a healthy and balanced diet
- Immunisations against preventable infections such as flu vaccine
- Early identification and screening of those who may have a health issue and access to early intervention.
- Access to information and advice on support services available

9.4.3 Factors which put health and wellbeing at risk

- Living with one or more long-term condition has a significant impact on an individuals health and well-being outcomes
- Falls: Older people, particularly women, are at greatest risk of falling and the morbidity associated with falls. Women experience a higher rate of associated injury including hip fractures; they also have less timely surgery (12% lower than the London and England average) and are more likely to be readmitted after hip replacement. Health and social care costs associated with falls are high and set to increase as the population ages. Rates of hip fracture, mortality within 30-days of hip fracture and readmission to hospital within 28 days are all linked to deprivation. Falls per year in Harrow are predicted to rise from 12,650 per year to 23,800 in the next 20 years.
- Poverty: Fuel poverty has increased and Harrow is ranked the second-worst in London (at 11.7%) by the Department of Energy and Climate Change (DECC) based on an income/cost analysis.
- Poor quality housing: living conditions can significantly affect health contributing to many health problems including respiratory illness, hypothermia, arthritis, cancer, heart attacks and strokes, as well as accidents in the home.
- Isolation and loneliness: Quality of Life survey indicates that 26% of Adult Social care users do not have as much social contact as they would like. The ONS estimates 17% of all individuals over 80 were often lonely and a further 29% were lonely some of the time. Feeling lonely and socially isolated in older age has been suggested to be as harmful to health as smoking 15 cigarettes a day[33]. The perceived or actual lack of a social network can affect all ages but the overlapping issues of bereavement, retirement, moving home and the onset of ill health means older people may be disproportionately affected. One might think in an urban, densely populated area such as Harrow, there's less opportunity to feel lonely because we are surrounded by people? Actually, the reverse holds true; social exclusion in the elderly is 2.5 times greater in densely population areas compared to rural areas. Physical and mental health, social demographic factors such as household composition, being a carer, driving status, access to transport and the built environment are all important risk factors. Research into loneliness and social isolation is at an early stage but the campaign to end loneliness has developed some potentially useful tools.

- Lack of early diagnosis and access to services: An early diagnosis of conditions such as dementia means that older people and their families can seek advice and information and be actively involved in planning their care. NHS England has set local targets for diagnosing dementia however Harrow's diagnosis rate is below the 48% England average; in 2013/14 39% of people with dementia had received a diagnosis, leaving an estimated 61% without a diagnosis[34]. The numbers of people with dementia from Black and Minority Ethnic groups is predicted to rise over the coming years because high blood pressure, diabetes, stroke and heart disease are more common in these communities and these are risk factors for dementia. These communities also tend to access services later, which can have a negative impact on families as they may have struggled for longer without support.
- Carers are vital to the wellbeing and independence of thousands of older people. The caring role can be stressful and isolating. The demands of being a carer can affect a person's quality of life. People providing high levels of care are twice as likely to be permanently sick or disabled.

10. What will the Harrow Health and Wellbeing Board do to achieve the vision?

10.1 Use every opportunity to promote mental wellbeing

We discussed in a previous chapter how our mind, body, heart and spirit are all components of wellbeing and that they should not be separated and viewed in isolation. However, mental health is a huge issue which some people say does not receive the same attention as physical health. We want to change this in Harrow to ensure we abide by the mantra 'there is no health without mental health.'

It's likely that you will know someone who has been off work due to 'stress', suffered from depression, anxiety or a severe mental health disorder such as schizophrenia or bipolar disorder. That's because it's common - 1 in 4 of us will experience mental 'ill health' during our lifetime. What you might not be aware of is that for many, the issues develop in childhood. Half of all those with lifelong mental illness developed them by age 14, 75% before age 18. In an average classroom of 5-16 year olds, 3 are affected by a mental health problem (1 in 10 of 5 to 16 year olds).

Conversely, positive mental wellbeing is associated with better education, finances, employment prospects, health and wellbeing.

Clearly access to mental health services is vitally important to ensure those with mental health problems get the support they require as early as possible to recover or live well with their condition. We know that nationally, 75% of people receive no treatment at all despite having a diagnosable mental health condition. If this was the case for cancer or cardiovascular disease, there would be uproar about the inequality. And yet people in general can often seem less empathetic about the role our minds play in determining our overall health and wellbeing. Mental health service improvement has therefore got to be a feature of our vision for the future. However, service improvement is not the only answer as far as Harrow Health and Wellbeing Board are concerned; even if we could improve services to meet the needs of everyone with a mental health problem in Harrow, we'd still only reduce the burden of disease by 28%[35].

The Harrow Health and Wellbeing Board have committed to a vision which enables residents to start, live, work and age well. This means if we are serious about improving mental wellbeing in Harrow, we need to think about what contribution education, housing, green spaces, employment, financial security, neighbourhoods and social connections make. At present, those responsible for these areas of work might not have thought about the impact they could make on health and wellbeing. To be successful, this strategy must sit at the

heart of all commissioning intentions in the future. That way, everyone can see the difference that their work makes to the people of Harrow now and in the future.

This area of work in Harrow will be informed by the Like Minded programme, a strategy to improve mental health and wellbeing across North West London. The programme has the aim of establishing excellent, integrated mental health services to improve mental and physical health. Further information about the programme, including the case for change, can be found on http://www.healthiernorthwestlondon.nhs.uk/mental-health.

There are four key workstreams to this Like Minded programme as follows:

- Living well with serious and long term mental health needs
- Common mental health needs
- Wellbeing and prevention
- Children and young people.

Work in Harrow will support and link directly with this strategy as well as to the Future in Mind programme. Future in mind is a national report that was published in March 2015, its purpose is; promoting, protecting and improving children and young people's mental health and wellbeing. The report was produced by the Children and Young People's Mental Health and Wellbeing Taskforce, who were mandated to consider ways to make it easier for children, young people, parents and carers to access help and support when needed and to improve how children and young people's mental health services are organised, commissioned and provided. The aim is to work towards preventative integrated provision to maximise children and young people's health outcomes.

The report makes 49 recommendations to improve young people's mental health services over the next five years and to enable an additional 70,000 young people to be treated by 2020. The recommendations are grouped under five headings:

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care of the most vulnerable
- Accountability and transparency
- Developing the workforce

Harrow Health and Wellbeing Board will support collaborative action, through this programme, which will bring about transformation for children and young people's mental health in Harrow.

10.2 Empower the community and voluntary sector to collaborate to deliver alternative delivery models and funding solutions

We heard during the engagement exercises that the community and voluntary sector is the lifeblood of Harrow and it makes a significant difference to health and wellbeing in Harrow.

We heard that there is a huge amount of community spirit to help each other but a need for more coordinated, joined up working. Health and wellbeing, specifically the endeavour to help all in Harrow start, live, work and age well could be the glue which joins everyone together.

If we, as the Health and Wellbeing Board, could establish the right networks, support mechanisms and shared programmes of work, residents would feel more engaged in local decision making and empowered to do more. The voluntary sector would seem more integrated; each organisation still advocating for a particular cause, but better able to serve

the needs of a diverse community with complex and inter-related need, knowing when to and how to collaborate. There would be less duplication across the whole system, better use of scarce resources and more opportunities to draw new investment into Harrow.

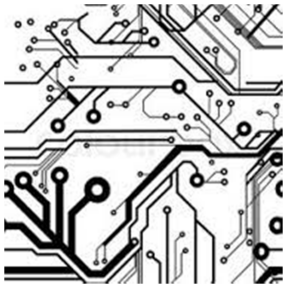
Take volunteering as an example. We know that there are a numerous volunteering schemes under way which have an impact on health and wellbeing including:

- Community Champions (run by Harrow Council Resources team)
- Health Champions (run by Harrow Council Public Health team)
- Arts/Museum Ambassadors (run by Harrow Council Community and Culture team)
- The new Community Click scheme (run by Age UK)
- 1-4-1 scheme for Harrow Council employees where they can swap out 1 hour of paid work for 1 hour of volunteering locally (not currently active)
- Park User Groups
- The Metropolitan Police specials
- Northwick Park's League of Friends
- Regeneration Residents Panel
- Youth Parliament
- Health volunteering pilot (run by Harrow CCG and Third Sector Potential)
- Plus local voluntary sector groups such as St Luke's Hospice, Mind in Harrow, Citizens Advice Bureau, Harrow Mencap, Age UK all rely on volunteers and have their own approaches to recruiting, training and volunteers.

Similarly, there are a whole host of ways in which we all try to get health and wellbeing messages out to residents, try to engage residents in decision making and signpost them to the right information, advice, place or service. Harrow Community Action consortium is now overseeing a new 'Support and Wellbeing Information Service for Harrow' (SWISH)[2], commissioned by Harrow Council. Harrow Advice Together is a partnership between thirteen voluntary organisations which signposts Harrow residents to information and advice. My Harrow, a Harrow Council portal currently enables online access to services such as Council tax and has in the region of 70,000 registered residents.

Wouldn't it be fantastic if we had a way of joining all this excellent work together? It would mean that anyone wanting to do more for their community knew where to go and offer their support to best effect and that they were linked up with a whole range of other volunteers passionate to make a difference in Harrow. It would mean that anyone trying to find information, advice, services and support – or just details of their nearest park to go for a walk – could find what they need. It would bring the community in Harrow closer together. It would enable us to build on what's already good in Harrow and promote it rather than just focusing on the gaps. It would stop us labelling people according to disease groups or vulnerability. It would mean that wherever people go, they can access the same connected information which promotes health and wellbeing.

That is not to say what is being proposed here is a 'single point of access' with one organisation having to take responsibility for keeping all information up to date and through which all residents must come to find what they need. A 'one size fits all' approach will not work in a diverse community like Harrow. Instead, like a circuit board on a computer, our ambition is for everything to become more linked up, interconnected and interdependent.



[2] http://www.harrowca.org.uk/support-wellbeing-information-service-harrow-swish/

The ambition of 'All together better', a third sector[3]' strategy for Harrow 2013-16 was similar; to 'optimise social capital[4] in Harrow' and to 'Deliver community empowerment and social capital through the collective effort and shared resources of local organisations'. The three themes set out in this document were 'public engagement', 'strengthening support' and 'collaboration'. However, consultation with leaders in this sector indicates there is still work to be undertaken by the sector to realise this vision.

Harrow Council is currently reviewing the way volunteering schemes are run by the Council. The Council would like to identify a simple and effective way to match volunteering opportunities to volunteers and to harness the enthusiasm of residents to engage in social action. This has come alongside the Government's wider ambitions to decentralise power, reduce reliance on the state and to encourage people to take an active role in their communities. It is important that the Health and Wellbeing Board considers ways in which these findings might be relevant and utilised across the wider health and wellbeing system.

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10.3 Provide integrated health and care services

Residents report finding the health and social care system fragmented and difficult to navigate. Integrated health and social care commissioning is vital for the future to improve quality, access, equity, cost effectiveness and efficiency. You have told members of the Health and Wellbeing Board that you want:

- Better access to care when it suits you
- To be equipped to do more for yourself
- Minimal handovers, which happen effectively and avoid loss of information
- To avoid having to repeat your story to multiple providers
- Support to set meaningful goals and care which is designed to help you meet your needs
- A system where the constituent parts communicate effectively with each other
- Information that is easily accessible
- Care plans which are up to date and that you have control over
- Unpaid and family carers to feel more empowered and able to provide day-to-day care.

These desires align with the Harrow-wide vision for whole systems integrated care which is to improve the quality of health and social care for individuals, carers and families, empowering and supporting people to maintain independence and lead full lives as active participants in their community.

The Care Act 2014 placed new duties on local authorities that require them to cooperate with local partners. Partners across Harrow believe that truly empowering people to help themselves requires support to be provided around people and not around existing organisational arrangements. Ideally, well before 2020 we will deliver integrated health and care services built around the needs of those using the services. By working in this way we believe we will:

[3] Not for profit independent, voluntary and community groups or organisations formed by local people, or those with a local interest, to improve the quality of life for themselves and/or fellow citizens in Harrow. These include registered charities, voluntary organisations, community groups, faith groups involved in social action, community interest companies and social enterprises[3].

[4] The connections between individuals and groups based on mutual trust and leading to a healthier society.

- Make life better for the people of Harrow.
- Prioritise home and community-based support to keep people well, and reduce the overuse of the emergency care system.
- Joined up, cost-effective services, making the most of the available resources.
- Planned in partnership between those that use them, stakeholders, providers and commissioners to ensure that they best meet the needs of Harrow.

11. How will this work be resourced?

There are significant financial pressures facing Harrow Health and Wellbeing Board partner organisations. Harrow as a whole receives one of the lowest funding allocation settlements in the Country and means we are in a significantly worse financial situation than other London boroughs. All Health and Wellbeing Board partners will collectively demand a fairer deal for Harrow from central Government.

There is no specific budget which the Health and Wellbeing Board has control over at present. However, this Strategy should inform the commissioning intentions of all partner organisations (including the voluntary sector) enabling a level of alignment which will facilitate opportunities for sharing resources in future, within respective annual agreed funding envelopes. Work is already underway to pool budgets through the Better Care Fund to unlock the benefit of integrated health and social care services.

12. How will we measure our impact?

It is proposed that the Harrow Health and Wellbeing Board monitor and evaluate implementation of this strategy as follows:

11.1 Monitor local health and wellbeing outcomes

As leaders in the health and care system in Harrow, the Health and Wellbeing Board must have a good overview of health and wellbeing in the borough and keep abreast of how that picture is changing over time.

It is important to state that Harrow CCG, Public Health, Children's Services and Adult Social Care already monitor a large number of outcomes based on the national outcomes frameworks detailed in the table below.

Table 1: NHS, Public Health and Adult Social Care Outcomes frameworks

Outcomes framework	**Indicator domains**				
NHS	Preventing people from dying prematurely	Enhancing quality of life for people with long term conditions	Helping people to recover from episodes of ill health or following injury	Ensuring people have a positive experience of care	Treating and caring for people in a safe environment and protecting them from avoidable harm
Public Health	Improving wider determinants	Health improvement	Health protection	Healthcare public health and preventing premature mortality	
Adult Social Care	Enhancing quality of life for people with care and support needs	Delaying and reducing the needs for care and support	Ensuring that people have a positive experience of care and support	Safeguarding people whose circumstances make them vulnerable and protecting them from avoidable harms	

Consequently, the Harrow Health and Wellbeing snapshot proposed does not seek to duplicate this, is not a performance management tool and the outcomes set out are not associated with targets which the Health and Wellbeing Board is responsible for.

The snapshot should help the Board focus attention on overall population health, wellbeing and inequalities and inform future work.

A proposal for the snapshot is set out in appendix 3. The snapshot will be reported at a frequency agreed by the Health and Wellbeing Board (data is available quarterly but changes in the indicators proposed would not necessarily be expected over such a short timescale). The data will be shared annually in a health and wellbeing newsletter.

11.2 Monitor implementation of specific annual actions
The Health and Wellbeing Board members responsible for the specific annual initiatives will develop some measurable actions by end of December each year which can be monitored quarterly. An annual report will be produced in December each year from 2016 onwards which will report on the specific annual actions and outline the actions planned for the year ahead. Finally, all partners will report on the extent to which the Health and Wellbeing Strategy has informed their commissioning intentions for the following year.

11.3 Partnership health check
To help the Health and Wellbeing Board monitor the effectiveness of their leadership, an annual partnership appraisal will be conducted to show we are serious about partnership.

13. How will the Health and Wellbeing Board do business in future?
We want all residents in Harrow to feel they have a say in the decisions taken by the Health and Wellbeing Board. We want residents to know what the plan for the future is and be kept informed about progress. We want to encourage everyone to get involved and to play a part in making Harrow a place where all can start, live, work and age well.

We heard that residents of Harrow want the Health and Wellbeing Board to:
- Consistently engage
- Join up engagement activity related to health and wellbeing across Harrow
- Say and show how the information that is collected is used

The Health and Wellbeing Board has listened to these requests and have a number of proposals to change the way we do business:

- *Health and Wellbeing innovation forums*

We will explore holding events in the community where a representative cross-section of residents can come together to discus health and wellbeing.

- *Create networked groups*

We will all support the development of networks to connect those interested in ‘start well’, ‘live well’, ‘work well’, ‘age well’ themes and co-ordinated approaches to connected consultations.

- *Themed agendas*

Where possible, the agenda will be split according to the start well, live well, work well, age well themes.

- *Clear relationship between the Health and Wellbeing Strategy and questions asked at the Health and Wellbeing Board*

Health and Wellbeing Board members will review all papers with consideration to the three priority areas asking 'does this paper demonstrate concern for mental wellbeing, integrated health and social care and building community capacity?'

- *New ways of communicating with residents*

An engaging digital newsletter summarising the work of the Health and Wellbeing Board will be produced every 3 months at the end of March, June, September and December. We will also explore other new ways of communicating with residents including through social media.

- *Facilitate joined up health and wellbeing engagement*

At present there are lots of different opportunities for residents to speak with different organisations about particular issues and periodically, Harrow CCG, Healthwatch, Harrow Council host engagement days to bring residents together or to consult on specific service changes or proposals. As a Health and Wellbeing Board, we need to plan more for the future together and consider where it is possible to bring people together once to discuss several issues rather than separately for each organisation. We will endeavour to link all partners together so we each have connected plans for engagement available to all our stakeholders.

- *Annual report*

An annual report will be produced in December each year which will report on the specific annual actions and all partners will report on the extent to which the Health and Wellbeing Strategy has informed their commissioning intentions for the following year.

Appendix 1 – report on work of Health and Wellbeing Board Task and Finish Groups

There were six joint commissioning intentions identified as part of the 2013-15 Health and Wellbeing Strategy. These were:

- Services for older people
- Dementia strategy
- Children's services
- Autism strategy
- Services for carers
- Safeguarding adults

Five task and finish groups were set up to deliver against these priorities and the local adults and children's safeguarding boards also critical for delivery.

- Dementia Task and Finish Group
- Children and Families Commissioning Executive Board
- Autism Task and Finish Group
- Carers Task and Finish Group
- Winterbourne Task and Finish Group
- Local Adults Safeguarding Board
- Local Children's Safeguarding Board

A progress report was presented to the Harrow Health and Wellbeing Board in 2014 outlining the key achievements of the Task and Finish Groups as follows:

Dementia Task and Finish Group
A draft Dementia Action Plan was developed out of the Dementia Engagement Day held in October 2013. The action plan highlighted the following issues:

- Training - a working group incorporating the 8 CCGs have agreed to jointly commission dementia awareness training. The aim is to target 17,000 trainees across NW London to be trained in dementia awareness at different levels. The trainees will include health and social care staff/carers/pharmacists and all relevant 3rd sector agencies across Harrow. The group is currently in discussions on how the training can best be rolled out in Harrow.
- Carers - it was decided that, in order to avoid duplication, the group would feed in to the Carers' Strategy being developed by Harrow Adult Social Care Commissioning.
- Ease of access to information, advice and guidance - content for a Harrow Council webpage is being developed which will provide information on dementia, list dementia related services available in Harrow and signpost people to specialist organisations for in-depth information.
- Easier Access to diagnosis and treatment - the restructured community based Memory Assessment Service went live in August 2014. One of its prime aims is to cut referral to assessment times from 6 months to 4 weeks. To be based in 3 GP surgeries, with therapeutic treatment also based in a number of community locations. Milman's Resource Centre being the first. GP's are also being incentivised to conduct more initial dementia screenings where relevant.
- Advance care planning/End of Life - it was decided that to avoid duplication, the group would feed into the work currently being undertaken by the CCGs End of Life Care Group.
- Care coordination, prevention and duplication - Whole Systems and Early Adopter Status, have focused on people 75 and over with one or more conditions – one of which is often dementia. Care coordinators are being hired for each of the six localities to ensure all relevant professions work together to develop personalised care plans.

- Dementia friendly communities - individual group members are in the process of signing up to a Harrow Dementia Alliance.

Following on from the Dementia Engagement Event and the draft Dementia Action Plan, the first iteration of a Joint Dementia Strategy 2015-2018 is being developed. This will replace the currently joint dementia strategy which ends in 2015. The strategy will be developed with Harrow CCG, people with dementia and their carers, Dementia Task & Finish Group and other relevant stakeholders. This strategy will link together with other commissioning strategies currently being developed e.g. carers' strategy.

Older People Integration Task and Finish Group (N.B. discontinued)
Since the last update report to the Health and Wellbeing Board, a decision was made to not implement the Older People Integration Task and Finish Group. This is because of the group's synergies with the Dementia Task and Finish Group, and to maximise resources in this area.

Children and Families Commissioning Executive Board
This commissioning executive is responsible for all joint commissioning for children and family services across Harrow. Significant areas of progress in the last six months include Special Educational Needs reforms where we are introducing a single health, education and care plan, local offer and individual budgets for children with SEN. We are also progressing health assessments for children looked after and putting in place an action plan to improve both quality and timeliness of assessments. Other areas of activity include redesigning pathways and support for children and young people with emotional, behavioural or mental health issues – across the full spectrum of needs, and planning the novation of health visiting to the local authority with NHSE.

Autism Task and Finish Group (formerly the Autism Project Board)
The very popular autism awareness training has continued to be provided to staff in Adult Social Care, Access Harrow and to other staff. More than 100 Harrow Council staff have attended the training since October 2013. The course has now been rolled out to staff working in mental health for Central and North West London NHS Trust. The one-day course aims to improve staff awareness of autism, enable them to identify signs of autism, know how to make reasonable adjustments and refer people to the diagnostic pathway and support.

A subgroup of the Autism task and finish group met to look at potential ideas for a bid to the government's Autism Innovation Fund. The subgroup was made up of representatives from Harrow Council, Harrow CCG, the voluntary sector, service users and carers. An identified priority for people with autism in Harrow is employment, and a bid to support autism awareness amongst Harrow employers has been put together. The group will continue to meet in order to develop and implement key employment objectives.

Carers Task and Finish Group
The Council and CCG are working together to develop a new commissioning action plan in support of unpaid carers. An "Expert Reference Group" has been brought together of carers from some key networks and groups to advise on the plan. Following agreement of the plan, which we expect in October, the Task and Finish group will be formed to oversee its delivery.

Winterbourne Task and Finish Group
Two well attended workshops were held in July 2014 to scope out the activity needed to continue the good work from the Winterbourne View action plan in Harrow. The group will continue to take forward improvement to support for people with learning disabilities, autism and challenging needs under three main work streams:

- Challenging needs – definition, diagnosis and pathways
- Learning disabilities – screening, diagnostic and assessment tools and support
- Improving access to universal services

This work is due to begin in October 2014 and will report back via the Winterbourne Task and Finish Group.

Local Adults Safeguarding Board
The Local Safeguarding Adults Board (LSAB) Annual Report 2013-14 is due to be presented at the Health and Wellbeing Board in September 2014.

Local Children's Safeguarding Board
The Local Safeguarding Childrens Board (LSCB) Annual Report 2013-14 is due to be presented at the Health and Wellbeing Board in September 2014.

Appendix 2

Visual minutes from Health and Wellbeing engagement event 16 July 2015 (part A)

Visual minutes from Health and Wellbeing engagement event 16 July 2015 (part B)

Appendix 3 – Harrow Health and Wellbeing Board health and wellbeing snapshot

		Indicator	England	London	Harrow	Worst performing ward	Best performing ward
Overall health indicators	1.	Life expectancy at birth (male)					
	2.	Life expectancy at birth (female)					
	3.	Healthy life expectancy at birth (male)					
	4.	Healthy life expectancy at birth (female)					
	5.	Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England (male)					
	6.	Slope index of inequality in healthy life expectancy at birth based on national deprivation deciles within England (female)					
Start well							
	7.	Infant mortality					
	8.	Children in poverty (all dependent children under 20)					
	9.	School readiness: at end of reception for children with free school meal status					
	10.	First time entrants to the youth justice system					
	11.	Tooth decay in children aged 5					
	12.	Childhood overweight/obesity at year y6					
	13.	Number of children and young people identified as at risk of Child Sexual Exploitation by the MASE panel					
	14.	Education outcomes of children looked after					
	15.	Emotional wellbeing of children looked after					
	16.	Maternal mental health					
	17.	Emergency admissions for Lower Respiratory Tract infections in children					
	18.	A&E attendances for accidental/non accidental injury					
Live well							
	19.	Mortality rate from causes considered to be preventable (persons)					
	20.	Excess under 75 mortality rate in adults with serious mental illness					

	21.	Homelessness acceptances (per thousand households)					
	22.	The percentage of respondents who answered 0-4 to the question “Overall, how happy did you feel yesterday?”					
	23.	Utilisation of outdoor space for exercise/health reasons					
	24.	Percentage of adults classified as physically inactive					
	25.	Domestic abuse					
Work well							
	26.	Percentage of 16-18 year olds not in education, employment or training (NEET)					
	27.	Percentage of working days lost due to sickness absence					
	28.	Gap in employment rate between those with a learning disability and the overall employment rate (persons)					
	29.	Gap in employment rate between those in contact with secondary mental health services and the overall employment rate					
	30.	Earnings by residence					
	31.	Earnings by workplace					
Age well							
	32.	Health related quality of life for people with long term conditions					
	33.	Health related quality of life for carers					
	34.	Social isolation: Percentage of adults social care users who have as much social contact as they would like					
	35.	Social isolation: percentage of adults carers who have as much social contact as they would like					
	36.	The percentage of households estimated to be fuel poor					
	37.	Hip fractures in over 65 (persons)					
	38.	Proportion of people living in their own home					

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REPORT FOR: **HEALTH AND SOCIAL CARE SCRUTINY SUB-COMMITTEE**

Date of Meeting:	26 October 2015
Subject:	Joint Health Overview and Scrutiny Committee Update
Responsible Officer:	Alex Dewsnap, Divisional Director Strategic Commissioning
Scrutiny Lead Member area:	Councillor Mrs Vina Mithani, Performance Lead & Councillor Michael Borio, Policy Lead Member
Exempt:	No
Wards affected:	All
Enclosures:	None

Section 1 – Summary and Recommendations

This report provides an update on the outcomes of the Joint Health Overview and Scrutiny Committee meeting held on 16 June 2015.

Recommendations:

That the sub-committee consider the update and provide any comments/ issues to be raised in advance of the next JHOSC meeting.

Section 2 – Report

2.1 The North West London Joint Overview and Scrutiny Committee (JHOSC) comprising of elected members drawn from the boroughs geographically covered by the NHS NW London *Shaping a Healthier Future* programme was set up to consider the proposals and consultation process formally between the period of 2 July and 8 October 2012.

The proposals set out the reconfiguration of the accident and emergency provision in North West London. This included changes to emergency maternity and paediatric care with clear implications on out-of- hospital care.

The JHOSC reported its final report in October 2012, making recommendations on how the *Shaping a Healthier Future* proposals could be developed and implemented including the risks that needed to be explored. This JHOSC also recommended that the committee continue to meet to provide strategic scrutiny of the development and implementation of *Shaping a Healthier Future.*

2.2 The 16 June meeting of the JHOSC covered the various issues as detailed below:

Shaping a Healthier Future

A Local Hospital at Ealing and Charing Cross
The committee received a briefing on the plans to turn both Charing Cross and Ealing Hospital into local hospitals, re-provisioning some of the acute services that they deliver.

Members heard that the Keogh Review to be published later in the year would provide details of the form local hospitals would take and a consultation relating to this will also be carried out. Members requested to have sight and be involved with the consolations as plans progressed.

Update on Implementation Business Case
Details of the progress of the Implementation Business Case (ImBC) were provided to the Committee. Following the agreement of the Secretary of State to develop the SaHF programme in October 2013, development work was

being undertaken on the ImBC which would provide the Strategic Outline Case (SOC) the capital investment required for delivery.

The ImBC will be based on the drafts of the Trusts acute business cases and the latest CCG Out of Hospital plans. It will reflect the current progress made on implementation and take into account the operational demands for health services in North West London as they stood. The ImBC format would use HM Treasury's five case models for business cases.

Members raised key questions relating to the need to fast track the out-of-hospital services in order to meet the changes in hospital. A key point was raised by the chair about the need to have early sight of key documents such as the ImBC as they are developed, and not afterwards.

As an outcome of discussions NHS colleagues agreed to provide a metrics of progress and a framework of activity on local and hospital settings on quality indicators.

Maternity Services Update

This item detailed the plans for the transition of maternity activity from Ealing Hospital. The report detailed the planned transition dates, shortly to commence as well as the further information on the future model for maternity activity in North West London.

The Panel were advised of the detailed assurances undertaken to support the decision, the model of care and implementation plan and the changes to gynaecology and paediatric services as well as an overview of the communications and engagement strategy which was in the process of being undertaken.

Members requested to have sight of the equalities impact assessment and transport impact assessment carried out as part of the transition exercise. The committee also stressed that the report failed to address/ promote home birth as part of the choice some mothers that were due to deliver could take as an alternative to going to another hospital.

North West London A&E Performance Update

The committee received a report which detailed the performance of North West London A&E departments over the preceding twelve months. The report detailed the actions which were being taken to improve the performance.

Members raised questions in relation to how spikes in attendance were dealt with which included management through extended hours admissions.
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Following discussions about the lack of clarity relating to some of the documentation, it was agreed that the committee would be provided with further statistics with a site by site breakdown of urgent care centre and A&E performance, including breakdowns by attendance type.

Discussion took place around the transfer of services from acute settings to

primary/community settings. It was agreed that public education was paramount to ensuring a smooth transition and culture change. A detailed analysis of how the 7 day GP Service was working across the boroughs was also to be provided at a future meeting.

There was then a discussion of the 111 telephone service. The existing contract for the service was coming to an end and research work was currently being undertaken and expected to be completed around September/October 2015 and the results would be presented to the committee at a future date.

JHOSC Work Programme and the remit of the Committee

Officers had been asked to review the possibility of the JHOSC widening its scope beyond its current focus on the Shaping a Healthier Future initiative into other key areas of the health agenda.

Following research, it was concluded that, without altering the membership of the JHOSC, it was unclear how it could expand its remit to encompass any additional key areas. It would also put significantly more demand on the workload of the committee and would require that meetings take place on a more regular basis. On the whole this would mean greater resources that are not available.

In conclusion, the committee agreed that it would be difficult to extend the scope without varying from the Committee's original remit. It was decided that wider issues were better considered at a borough level along the lines of current arrangements.

Financial Implications

None

Performance Issues

None

Environmental Impact

None

Risk Management Implications

None

Equalities implications

There are a number of equalities implications that relate to the reconfiguration of health services in North West London as a whole. These implications form part of the on-going considerations of the JHOSC.

Council Priorities

The work of JHOSC committee relates to all four of council's priorities:

- Making a difference for the most vulnerable
- Making a difference for communities
- Making a difference for local businesses
- Making a difference for families

Section 3 - Statutory Officer Clearance

Ward Councillors notified:	**NO**

Section 4 - Contact Details and Background Papers

Contact: Fola Irikefe, Policy Officer, 020 8420 9389

Background Papers: JHOSC Agenda, 16 June 2015

http://moderngov:8080/ieListDocuments.aspx?CId=1102&MId=62734

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